

1242

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>18 MO.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REEDER NURSING HOME</b>				d. STREET ADDRESS <b>110 N. ANTIETAM ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>EMMA</b> Last <b>ALBRIGHT</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/18/1868</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY PHILLIPS</b>				14. MOTHER'S MAIDEN NAME <b>MARY STRAUS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. FLORENCE BADGER FUNKSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/11/59</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 8</b> , 19 <b>59</b> , to <b>Jan 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 14</b> , 19 <b>59</b> , and that death occurred at <b>4</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>SIDNEY NOVENSTEIN</b> M.D. <b>Arthur S. Kraus</b> <b>MD 1/19/59</b> PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WATSONTOWN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WATSONTOWN PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hornum, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		CLINICAL FINDINGS	
DIAGNOSIS		PROGNOSIS	
TREATMENT		FOLLOW-UP	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

1161

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. county Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <b>Jan</b> Day <b>9</b> Year <b>1959</b>							
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>ELIZABETH</b> Last <b>ANTHONY</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1917</b>		9. AGE (In years last birthday) yrs. <b>42</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore City Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Shank</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Ebberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-05-6258</b>		17. INFORMANT <b>John Anthony 418 West Antelam St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of ileum</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Band of adhesion</b> DUE TO (c) <b>Previous operations</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ascites, Aspiration of Urine</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>11 May, 1956</b> , to <b>8 Jan, 1959</b> , that I last saw the deceased alive on <b>8 Jan, 1959</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Richard T. Binford</b> M.D. <b>9 JANUARY 1959</b>							
ACTUAL SIGNATURE <b>Richard T. Binford</b>				PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1162

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Arrington</u>				4. DATE OF DEATH Month Day Year <u>January 8 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Arrington</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent lobular pneumonia</u> <u>163X</u> DUE TO <u>metastatic carcinoma in mediastinum, retroperitoneal nodes, adrenals + liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>epidermoid carcinoma of rt. lung</u> (c) <u>epidermoid carcinoma of rt. lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>14 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 31</u> , 19 <u>58</u> , to <u>January 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 8</u> , 19 <u>59</u> , and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Victor L. Ramos</u> , M.D.				ADDRESS <u>Western Maryland State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, MD</u>				ADDRESS <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr</u> ADDRESS <u>Hagerstown MD</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

01110

REG. NO. 100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. TIME OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF WITNESSES</p>		<p>16. SIGNATURE OF FUNERAL HOME</p>	
<p>17. SIGNATURE OF BURIAL PLACE</p>		<p>18. SIGNATURE OF INTERMENT PLACE</p>	
<p>19. SIGNATURE OF CEMETERY</p>		<p>20. SIGNATURE OF BURIAL PLACE</p>	
<p>21. SIGNATURE OF INTERMENT PLACE</p>		<p>22. SIGNATURE OF CEMETERY</p>	
<p>23. SIGNATURE OF BURIAL PLACE</p>		<p>24. SIGNATURE OF INTERMENT PLACE</p>	
<p>25. SIGNATURE OF CEMETERY</p>		<p>26. SIGNATURE OF BURIAL PLACE</p>	
<p>27. SIGNATURE OF INTERMENT PLACE</p>		<p>28. SIGNATURE OF CEMETERY</p>	
<p>29. SIGNATURE OF BURIAL PLACE</p>		<p>30. SIGNATURE OF INTERMENT PLACE</p>	
<p>31. SIGNATURE OF CEMETERY</p>		<p>32. SIGNATURE OF BURIAL PLACE</p>	
<p>33. SIGNATURE OF INTERMENT PLACE</p>		<p>34. SIGNATURE OF CEMETERY</p>	
<p>35. SIGNATURE OF BURIAL PLACE</p>		<p>36. SIGNATURE OF INTERMENT PLACE</p>	
<p>37. SIGNATURE OF CEMETERY</p>		<p>38. SIGNATURE OF BURIAL PLACE</p>	
<p>39. SIGNATURE OF INTERMENT PLACE</p>		<p>40. SIGNATURE OF CEMETERY</p>	
<p>41. SIGNATURE OF BURIAL PLACE</p>		<p>42. SIGNATURE OF INTERMENT PLACE</p>	
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<p>45. SIGNATURE OF INTERMENT PLACE</p>		<p>46. SIGNATURE OF CEMETERY</p>	
<p>47. SIGNATURE OF BURIAL PLACE</p>		<p>48. SIGNATURE OF INTERMENT PLACE</p>	
<p>49. SIGNATURE OF CEMETERY</p>		<p>50. SIGNATURE OF BURIAL PLACE</p>	
<p>51. SIGNATURE OF INTERMENT PLACE</p>		<p>52. SIGNATURE OF CEMETERY</p>	
<p>53. SIGNATURE OF BURIAL PLACE</p>		<p>54. SIGNATURE OF INTERMENT PLACE</p>	
<p>55. SIGNATURE OF CEMETERY</p>		<p>56. SIGNATURE OF BURIAL PLACE</p>	
<p>57. SIGNATURE OF INTERMENT PLACE</p>		<p>58. SIGNATURE OF CEMETERY</p>	
<p>59. SIGNATURE OF BURIAL PLACE</p>		<p>60. SIGNATURE OF INTERMENT PLACE</p>	
<p>61. SIGNATURE OF CEMETERY</p>		<p>62. SIGNATURE OF BURIAL PLACE</p>	
<p>63. SIGNATURE OF INTERMENT PLACE</p>		<p>64. SIGNATURE OF CEMETERY</p>	
<p>65. SIGNATURE OF BURIAL PLACE</p>		<p>66. SIGNATURE OF INTERMENT PLACE</p>	
<p>67. SIGNATURE OF CEMETERY</p>		<p>68. SIGNATURE OF BURIAL PLACE</p>	
<p>69. SIGNATURE OF INTERMENT PLACE</p>		<p>70. SIGNATURE OF CEMETERY</p>	
<p>71. SIGNATURE OF BURIAL PLACE</p>		<p>72. SIGNATURE OF INTERMENT PLACE</p>	
<p>73. SIGNATURE OF CEMETERY</p>		<p>74. SIGNATURE OF BURIAL PLACE</p>	
<p>75. SIGNATURE OF INTERMENT PLACE</p>		<p>76. SIGNATURE OF CEMETERY</p>	
<p>77. SIGNATURE OF BURIAL PLACE</p>		<p>78. SIGNATURE OF INTERMENT PLACE</p>	
<p>79. SIGNATURE OF CEMETERY</p>		<p>80. SIGNATURE OF BURIAL PLACE</p>	
<p>81. SIGNATURE OF INTERMENT PLACE</p>		<p>82. SIGNATURE OF CEMETERY</p>	
<p>83. SIGNATURE OF BURIAL PLACE</p>		<p>84. SIGNATURE OF INTERMENT PLACE</p>	
<p>85. SIGNATURE OF CEMETERY</p>		<p>86. SIGNATURE OF BURIAL PLACE</p>	
<p>87. SIGNATURE OF INTERMENT PLACE</p>		<p>88. SIGNATURE OF CEMETERY</p>	
<p>89. SIGNATURE OF BURIAL PLACE</p>		<p>90. SIGNATURE OF INTERMENT PLACE</p>	
<p>91. SIGNATURE OF CEMETERY</p>		<p>92. SIGNATURE OF BURIAL PLACE</p>	
<p>93. SIGNATURE OF INTERMENT PLACE</p>		<p>94. SIGNATURE OF CEMETERY</p>	
<p>95. SIGNATURE OF BURIAL PLACE</p>		<p>96. SIGNATURE OF INTERMENT PLACE</p>	
<p>97. SIGNATURE OF CEMETERY</p>		<p>98. SIGNATURE OF BURIAL PLACE</p>	
<p>99. SIGNATURE OF INTERMENT PLACE</p>		<p>100. SIGNATURE OF CEMETERY</p>	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Yr</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>Maryland Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>542 George St</b>						d. STREET ADDRESS <b>542 George St</b>					
3. NAME OF DECEASED (Type or print) <b>MARGARET VERNON BARROW</b>						4. DATE OF DEATH <b>January 16 1959 19</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Oct 30 1908</b>		9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>presser</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>L'Aiglon Dress Co</b>				11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Max Lorshbaugh</b>						14. MOTHER'S MAIDEN NAME <b>Grace Kriner</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-09-9456</b>		17. INFORMANT <b>Marvin F. Rogers 627 George St Hagerstown Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b>		(County) <b>-</b> (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>						24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SOCIETY	
1000 E. BALTIMORE AVE.		DRIVER		HIGH SCHOOL		MARRIED		METHODIST		MEMBER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
JAN 1, 1968		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST	
TIME OF DEATH		HOURS		MINUTES		AM		PM		TEMPERATURE	
10:00		10		00		10		00		98.6	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		COUNTY		STATE	
JAMES EARL RAY		M.D.		JAN 1, 1968		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF WITNESS		TITLE		DATE		PLACE		COUNTY		STATE	
JAMES EARL RAY		M.D.		JAN 1, 1968		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF CORONER		TITLE		DATE		PLACE		COUNTY		STATE	
JAMES EARL RAY		M.D.		JAN 1, 1968		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF JURY		TITLE		DATE		PLACE		COUNTY		STATE	
JAMES EARL RAY		M.D.		JAN 1, 1968		BALTIMORE		BALTIMORE		MD.	

1164

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715 Potomac Ave.</u>				e. STREET ADDRESS <u>715 Potomac Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>VERA</u> Middle <u>LINDOL</u> Last <u>BEATTY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 19, 1987</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Carlisle, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Morrett</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Stambaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>A. Wayne Beatty</u> Address <u>715 Potomac Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Several years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19</u> , 19 <u>50</u> , to <u>Jan. 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 6th</u> , 19 <u>59</u> , and that death occurred at <u>11 P</u> M; from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u> DATE SIGNED <u>1/24/59</u>							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D. <u>159 W. Washington St., Hagerstown, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>27 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

Wm. G. Hunt J. Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1165

Item 1 Film G237 1-14-59 et

CERTIFICATE OF DEATH

01165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"At home"</b>				d. STREET ADDRESS <b>661 Pin Oak Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gregory Raymond Boone</b>				4. DATE OF DEATH Month Day Year <b>January 5 19 59</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 3, 1957</b>		9. AGE (In years lost birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>G. Eugene Boone</b>				14. MOTHER'S MAIDEN NAME <b>Eva Leighty</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>G. Eugene Boone Hagerstown Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of Vomitus</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vomiting</b> DUE TO (c) <b>Influenza</b>												INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>1/3</b> , 19 <b>59</b> , to <b>1/5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/5</b> , 19 <b>59</b> , and that death occurred at <b>6:00 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard A. Young</b> ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>1/6/59</b> PHYSICIAN'S NAME (Type) <b>Richard A. Young</b> <b>101 King Street</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>						ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>					

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Washington

Maryland

Hagerstown

101 1st St. Drive

January

Hagerstown

Gregory

White

White

October 3, 1947

Home

Home

Hagerstown, Md.

Eva Lelch

E. Eugene Boone

E. Eugene Boone Hagerstown, Md.

Hill Street Pharmacy

Chesapeake

1-7-52

1-7-52

George F. Minnick & Son Hagerstown, Md.

1166

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>402 LIBERTY ST.</b>		d. STREET ADDRESS <b>1 402 LIBERTY ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>WORTH</b> Last <b>BOWERS</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/1871</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BRICK LAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CALVIN BOWERS</b>		14. MOTHER'S MAIDEN NAME <b>ELLENORRA MORGAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-05-2613</b>	
17. INFORMANT <b>MR. CLYDE BOWERS</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERIOSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 19 58</b> to <b>January 6, 19 59</b> that I last saw the deceased alive on <b>Nov 3, 19 58</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>1-7-59</b>			
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.		DATE SIGNED <b>1-7-59</b>	
PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Norment</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 9 '59</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAKING STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



1167

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>827 W. Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GOLDIE</b> Middle <b>PEARL</b> Last <b>BOYCE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1911</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>16</b>	11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dress Manufacture</b>	11. BIRTHPLACE (State or foreign country) <b>Winchester, Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Freeman Boyce</b>	
14. MOTHER'S MAIDEN NAME <b>Valley Bell Holliday</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-05-6487</b>		17. INFORMANT Address <b>Mrs. Mamie Everly Kemps Mill, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 mins.</b> <b>11 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 23, 1958</b> , to <b>January 30, 1959</b> , that I last saw the deceased alive on <b>January 10, 1959</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg. 1/31/59</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>William T. Layman</b> PHYSICIAN'S NAME (Type) <b>William T. Layman</b> <b>Hagerstown</b> <b>Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>81 Franklin Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01169

## 1168 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		HALFWAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 118 ROESSNER AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SELMA ANNETTA BROWNING		4. DATE OF DEATH Month Day Year JANUARY 11 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS F. KERFOOT		14. MOTHER'S MAIDEN NAME ANNA E. ARTHUR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 274-05-725	
17. INFORMANT MRS. ANNE E. RIEDTHALER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-8 1942 to 1-11, 1959, that I last saw the deceased alive on 1-11, 1959, and that death occurred at 11 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 154 West Washington St.,		DATE SIGNED 1-14-59	
ACTUAL SIGNATURE John H. Hornbaker M.D.			
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Hornum, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

Reg. Div. 100

100

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1169

## CERTIFICATE OF DEATH

01170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>1 2000 Gay Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Edward Bryan</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>18,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1908</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinery foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>aircraft ind.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James W. Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Cora Biser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-3313</b>	
17. INFORMANT <b>Nellie F. Bryan, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> <b>463X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>THROMBOPHLEBITIS, leg</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOGENIC CARCINOMA, RIGHT LUNG (recurrent) post-pneumonectomy</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 26</b> , 19 <b>58</b> , to <b>Jan. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 17</b> , 19 <b>59</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Kehne</b>		DATE SIGNED <b>131 W. Washington St.</b>	
PHYSICIAN'S NAME (Type) <b>John H. Kehne</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





## 1170 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>309 So Mulberry St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MARTHA</u> Last <u>BURKER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Welsh Run Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Bingham</u>				14. MOTHER'S MAIDEN NAME <u>Alice Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George M. Burkner 309 So Mulberry St</u> <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-12-59</u> to <u>1-14-59</u> , that I last saw the deceased alive on <u>1-14-59</u> , 19 <u>  </u> , and that death occurred at <u>6:30</u> M. from the causes and on the date stated above. Hagerstown, Md. DATE SIGNED <u>1/13/59</u>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto III</u>				M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto III</u>				<u>217 W. Washington St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Attest: [Signature]

PLACE OF DEATH HOME		COUNTY BALTIMORE	
STREET 1234 E. BALTIMORE AVE.		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
DECEASED'S NAME JOHN DOE		SEX MALE	
DATE OF BIRTH JAN 15 1925		AGE 76	
PLACE OF BIRTH BALTIMORE, MD		RACE WHITE	
OCCUPATION RETIRED		MARRIAGE <input checked="" type="checkbox"/> MARRIED	
MARITAL STATUS MARRIED		DATE OF MARRIAGE 1948	
NAME OF SPOUSE JANE DOE		DATE OF DEATH DEC 10 1999	
TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
ICD-10 CODE I25.9		ICD-9 CODE 435.91	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
DATE DEC 10 1999		TIME 10:00 AM	

RECEIVED

DEPT. OF HEALTH  
BALTIMORE, MD

1171

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 mo.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Hagerstown R#4</b>				d. STREET ADDRESS <b>Hagerstown R#4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>MARTHA</b> Last <b>CARPENTER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1900</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George W. Metz</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jane Lizer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-05-6396</b>		17. INFORMANT <b>Clinton F. Carpenter R#4 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Core Brain Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/24/59</b> to <b>1/25/59</b> , that I last saw the deceased alive on <b>1/25/59</b> , and that death occurred <b>6:55 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Williamsport, Md.</b> DATE SIGNED <b>1/25/59</b>							
ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D.				DATE SIGNED <b>1/25/59</b>			
PHYSICIAN'S NAME (Type) <b>Ralph F. Young M.D.</b>				<b>Williamsport, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED          [Handwritten: John Doe]</p>		<p>2. SEX          [Handwritten: Male]</p>		<p>3. AGE          [Handwritten: 45]</p>	
<p>4. DATE OF DEATH          [Handwritten: 10/15/1918]</p>		<p>5. TIME OF DEATH          [Handwritten: 10:00 AM]</p>		<p>6. PLACE OF DEATH          [Handwritten: Home]</p>	
<p>7. OCCUPATION          [Handwritten: Farmer]</p>		<p>8. CAUSE OF DEATH          [Handwritten: Pneumonia]</p>		<p>9. MANNER OF DEATH          [Handwritten: Natural]</p>	
<p>10. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>11. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>12. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>13. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>14. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>15. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>16. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>17. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>18. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>19. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>20. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>21. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>22. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>23. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>24. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>25. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>26. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>27. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>28. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>29. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>30. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>31. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>32. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>33. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>34. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>35. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>36. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>37. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>38. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>39. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>40. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>41. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>42. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>43. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>44. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>45. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>46. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>47. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>48. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>49. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>50. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>51. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>52. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>53. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>54. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>55. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>56. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>57. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>58. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>59. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>60. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>61. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>62. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>63. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>64. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>65. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>66. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>67. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>68. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>69. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>70. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>71. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>72. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>73. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>74. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>75. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>76. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>77. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>78. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>79. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>80. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>81. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>82. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>83. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>84. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>85. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>86. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>87. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>88. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>89. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>90. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>91. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>92. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>93. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	
<p>94. PLACE OF BIRTH          [Handwritten: Baltimore, Md.]</p>		<p>95. DATE OF BIRTH          [Handwritten: 10/15/1873]</p>		<p>96. SEX OF BIRTH          [Handwritten: Male]</p>	
<p>97. OCCUPATION OF BIRTH          [Handwritten: Farmer]</p>		<p>98. CAUSE OF BIRTH          [Handwritten: Natural]</p>		<p>99. MANNER OF BIRTH          [Handwritten: Natural]</p>	
<p>100. SIGNATURE OF PHYSICIAN          [Handwritten: Dr. J. Smith]</p>		<p>101. SIGNATURE OF CORONER          [Handwritten: W. Jones]</p>		<p>102. SIGNATURE OF WITNESSES          [Handwritten: A. Brown, C. White]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

01173

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>35 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>230 Summit Ave.</b>		d. STREET ADDRESS <b>230 Summit Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>SALLIE</b> First <b>Elsie</b> Middle <b>CHANCE</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1893</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ribbon Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ribbon Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>South Chester, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Chance</b>		14. MOTHER'S MAIDEN NAME <b>Cierra E. Kaetzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-3144</b>	
17. INFORMANT <b>Mr. G. Henry Leatherman</b>		Address <b>Myersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Acute Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>1-19-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Ronzer Funeral Home</b> <b>R. Franklin Rye</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE  
WEST

302

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Chance	
Sex		Male	
Race		White	
Age		3 years	
Date of Birth		January 17, 1935	
Place of Birth		Washington, D.C.	
Residence		230 North Ave., Baltimore, Md.	
Cause of Death		Infantile Parotitis	
Date of Death		January 17, 1935	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	
Date of Examination		January 17, 1935	
Place of Examination		Home	
Signature of Coroner		[Signature]	
Date of Certification		January 17, 1935	
Place of Certification		Baltimore, Md.	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1173

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

WASHINGTON

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X LAPPANS RURAL

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASH.CO.HOSPITAL

d. STREET ADDRESS

FAIRPLAY MD.ROUTE 1.

e. IS RESIDENCE  
ON A FARM?  
YES ☒ NO ☐3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

DOLLY

VIRGINIA

CLIPP

4. DATE  
OF  
DEATH

Month

Day

Year

JANUARY 8 1959

19

## 5. SEX

FEMALE

## 6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

APRIL 4 1920

9. AGE (In years  
last birthday)

38 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

## 10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

## 11. BIRTHPLACE (State or foreign country)

FALLING WATERS W.VA.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

HARRY MILLER

## 14. MOTHER'S MAIDEN NAME

FLORENCE YARLETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

NO

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

NONE

## 17. INFORMANT

Address

WILLIS L. CLIPP FAIRPLAY MD.R.1

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute coronary occlusion

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

## 20c. TIME OF INJURY

Month, Day, Year

Hour a. m. none p. m.

19

## 20d. INJURY OCCURRED

While of work ☐Not while at work ☒

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

none

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

S. Robert Wells

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

## DATE SIGNED

1-10-59

EXAMINER'S  
NAME (Type)

S. Robert Wells, M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

## 22b. DATE THEREOF

JAN. 11 1959

## 22c. NAME OF CEMETERY OR CREMATORY

MOUNTAIN VIEW CEMETERY SHARPSBURG WASH.CO.MD.

## 22d. LOCATION (City, town, or county)

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

John D. East

## ADDRESS

Boonsbury Md

## 24a. REC'D BY REGISTRAR

JAN 14 '59

DATE

## 24b. REGISTRAR'S SIGNATURE

Arthur L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>	
<p>9. PRESENT RESIDENCE</p>		<p>10. DATE OF DEATH</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>	
<p>13. SIGNATURE OF EXAMINER</p>		<p>14. SIGNATURE OF WITNESS</p>	
<p>15. DATE OF EXAMINATION</p>		<p>16. TIME OF EXAMINATION</p>	
<p>17. PLACE OF EXAMINATION</p>		<p>18. NAME OF HOSPITAL</p>	
<p>19. NAME OF PHYSICIAN</p>		<p>20. NAME OF NURSE</p>	
<p>21. NAME OF ASSISTANT</p>		<p>22. NAME OF ATTENDING</p>	
<p>23. NAME OF SURGEON</p>		<p>24. NAME OF ANESTHETIC</p>	
<p>25. NAME OF DRUG</p>		<p>26. NAME OF INSTRUMENT</p>	
<p>27. NAME OF SUPPLY</p>		<p>28. NAME OF EQUIPMENT</p>	
<p>29. NAME OF MATERIAL</p>		<p>30. NAME OF SUPPLEMENT</p>	
<p>31. NAME OF ADDITIVE</p>		<p>32. NAME OF FLAVORING</p>	
<p>33. NAME OF COLORING</p>		<p>34. NAME OF PRESERVATIVE</p>	
<p>35. NAME OF STABILIZER</p>		<p>36. NAME OF EMULSIFIER</p>	
<p>37. NAME OF SUSPENDING AGENT</p>		<p>38. NAME OF SOLVENT</p>	
<p>39. NAME OF ADJUVANT</p>		<p>40. NAME OF CARRIER</p>	
<p>41. NAME OF DILUENT</p>		<p>42. NAME OF BUFFER</p>	
<p>43. NAME OF pH ADJUSTER</p>		<p>44. NAME OF OSMOTIC ADJUSTER</p>	
<p>45. NAME OF ISOTONIC ADJUSTER</p>		<p>46. NAME OF STERILIZER</p>	
<p>47. NAME OF FILTER</p>		<p>48. NAME OF VESSEL</p>	
<p>49. NAME OF TUBING</p>		<p>50. NAME OF CONNECTOR</p>	
<p>51. NAME OF CLAMP</p>		<p>52. NAME OF STOPPER</p>	
<p>53. NAME OF CAP</p>		<p>54. NAME OF SEAL</p>	
<p>55. NAME OF GASKET</p>		<p>56. NAME OF O-RING</p>	
<p>57. NAME OF BUSHING</p>		<p>58. NAME OF FITTING</p>	
<p>59. NAME OF VALVE</p>		<p>60. NAME OF REGULATOR</p>	
<p>61. NAME OF PRESSURE GAUGE</p>		<p>62. NAME OF FLOW METER</p>	
<p>63. NAME OF TEMPERATURE SENSOR</p>		<p>64. NAME OF PH SENSOR</p>	
<p>65. NAME OF OSMOMETER</p>		<p>66. NAME OF ISOTONICITY METER</p>	
<p>67. NAME OF STERILITY MONITOR</p>		<p>68. NAME OF PARTICULATE METER</p>	
<p>69. NAME OF ENDOTOXIN METER</p>		<p>70. NAME OF BACTERIAL METER</p>	
<p>71. NAME OF VIRAL METER</p>		<p>72. NAME OF FUNGUS METER</p>	
<p>73. NAME OF PARASITE METER</p>		<p>74. NAME OF TOXIN METER</p>	
<p>75. NAME OF ANTIBODY METER</p>		<p>76. NAME OF ANTIGEN METER</p>	
<p>77. NAME OF ENZYME METER</p>		<p>78. NAME OF HORMONE METER</p>	
<p>79. NAME OF VITAMIN METER</p>		<p>80. NAME OF MINERAL METER</p>	
<p>81. NAME OF AMINO ACID METER</p>		<p>82. NAME OF SUGAR METER</p>	
<p>83. NAME OF LIPID METER</p>		<p>84. NAME OF PROTEIN METER</p>	
<p>85. NAME OF NUCLEIC ACID METER</p>		<p>86. NAME OF CARBOHYDRATE METER</p>	
<p>87. NAME OF CELL METER</p>		<p>88. NAME OF TISSUE METER</p>	
<p>89. NAME OF ORGANELLE METER</p>		<p>90. NAME OF MOLECULE METER</p>	
<p>91. NAME OF ATOM METER</p>		<p>92. NAME OF ION METER</p>	
<p>93. NAME OF RADIATION METER</p>		<p>94. NAME OF MAGNETIC FIELD METER</p>	
<p>95. NAME OF ELECTRIC FIELD METER</p>		<p>96. NAME OF SOUND METER</p>	
<p>97. NAME OF VIBRATION METER</p>		<p>98. NAME OF ACCELERATION METER</p>	
<p>99. NAME OF ROTATION METER</p>		<p>100. NAME OF TORSION METER</p>	

1243  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder's Nursing Home</b>		d. STREET ADDRESS <b>Church Hill</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES Theodore CULLER</b> First Middle Last		4. DATE OF DEATH <b>JAN. 28</b> 19 <b>59</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 29, 1911</b> 47 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Culler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Zimmerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Anna M. Culler (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Viral Pneumonia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumococcus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Sharp</b> <b>Two</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 10, 1959</b> to <b>January 28, 1959</b> , that I last saw the deceased alive on <b>January 28, 1959</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. LeVan M.D.</b>		ADDRESS (Street, city or town, state) <b>Boonsboro Md</b>	
PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		DATE SIGNED <b>1/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 2 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>William E. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
HARRISON		JAN 10 1900	
SEX		AGE	
MALE		25	
RACE		COLOR	
WHITE		WHITE	
BIRTH		PLACE OF BIRTH	
JAN 10 1875		NEW YORK	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		PERIOD OF ILLNESS	
NATURAL		10 DAYS	
PLACE OF DEATH		DATE OF INTERMENT	
NEW YORK		JAN 12 1900	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
DR. J. H. BROWN		J. H. BROWN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME	
J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 12 1900		JAN 12 1900	
NAME OF REGISTRAR		NAME OF COUNTY	
J. H. BROWN		NEW YORK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 12 1900		JAN 12 1900	

1174

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Cunningham</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>George Clinton Young</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Arthur S. R. Cunningham</u>				Address <u>Williamsport Md RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Williamsport</u>				20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1/1/59</u> , 19 <u>59</u> , to <u>1/1/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/1/59</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. (ADDRESS (Street, city or town, state) DATE SIGNED <u>Williamsport Md</u> <u>1/2/59</u>							
ACTUAL SIGNATURE <u>Albert Leaf</u>				M.D. <u>Williamsport Md</u>			
PHYSICIAN'S NAME (Type) <u>Albert Leaf</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. R. Cunningham</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1175

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>7 Hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash. County Hospital</b>				e. STREET ADDRESS <b>8 Suters Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY IRENE DAGENHART</b>				4. DATE OF DEATH Month Day Year <b>January 21 1959 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 28 1925 33 yrs.</b>	
9. AGE (In years last birthday) <b>33</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel K. Welch</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unable to locate</b>			
17. INFORMANT <b>Wanda C. Turner</b>				Address <b>8 Suters Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Hypertensive Vascular Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-20-59</b> , to <b>1-21-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-20-59</b> , 19 <b>59</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>D. E. Coffman</b> M.D. <b>Andrew K. Coffman</b> PHYSICIAN'S NAME (Type) <b>ANDREW K. COFFMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10



1176

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elaine</b> Last <b>Danzberger</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>21,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1923</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife and Beautician</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Grimm</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Leshner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles E. Danzberger, 132 John St., Hagerstown</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma</b> DUE TO (c) <b>Adeno Carcinoma - Rt. breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b> <b>3 yrs.</b> <b>6 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> <b>1956</b> to <b>Jan. 21</b> <b>1959</b> , that I last saw the deceased alive on <b>Jan 20</b> <b>1959</b> , and that death occurred at <b>5:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1121 159 Potomac st</b> DATE SIGNED <b>1/21/59</b> ACTUAL SIGNATURE <b>Clad A. Hoffman</b> M.D. <b>214 N. Potomac st</b> PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b> <b>Hagerstown</b> <b>Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Shaw, Waynesboro Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Shaw</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1177 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Williamsport R#2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Rural</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PALMER</b> Middle <b>JENNINGS</b> Last <b>DAWSON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1890</b>
		9. AGE (In years lost birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>	11. BIRTHPLACE (State or foreign country) <b>Luray, Va.</b>
13. FATHER'S NAME <b>Joseph Dawson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Weaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3500</b>	
		17. INFORMANT <b>Jennings P. Dawson</b> Address <b>Hagerstown, Md. 505 Dunn Irvin Drive,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma from Bowel</b> DUE TO (c) <b>6 mos</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-5 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>Aug</b> Day <b>1</b> Year <b>1958</b> Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>58</b> , to <b>Jan 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 14</b> , 19 <b>59</b> , and that death occurred at <b>3:02</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Max Byrkit</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>2844 Patomac</b> <b>1-16-59</b>	
PHYSICIAN'S NAME (Type) <b>Max Byrkit M.D.</b>		<b>Williamsport Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01180

1244  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>31yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RD # 2 Smithsburg</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>H.</b> Last <b>DETROW</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1875</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beaver Creek, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Detrow</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>271-32-6566</b>	
17. INFORMANT <b>Mrs. Clarence Duffey, RD # 2, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Sigmoid Colon with metastases</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Inguinal Hernia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/11</b> , 19 <b>57</b> , to <b>1/4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/19</b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>1/5/59</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b>		M.D. _____	
PHYSICIAN'S NAME (Type) <b>Charles F Hess M.D.</b>		<b>Smithsburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 7, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Martin POE</b>		ADDRESS <b>Waynesboro, Penna.</b>	
24a. REC'D BY REGISTRAR <b>JAN 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-3-59-  
D.M.E.- Washington County

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

01181

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 1/2 West Franklin Street</b>		d. STREET ADDRESS <b>24 1/2 West Franklin Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>EDGAR</b> Last <b>DOARNBERGER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Silk Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ribbon Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Doarnberger</b>		14. MOTHER'S MAIDEN NAME <b>Rosana Fridinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-3156</b>	
17. INFORMANT <b>Mr. George Doarnberger</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 yr.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>Jan 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 21</b> , 19 <b>58</b> , and that death occurred at <b>11 A-M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>1/2/59</b>			
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>		FUNDING DIRECTOR'S SIGNATURE <b>Lloyd A. Hoffman</b>	
NAME (Type) <b>Lloyd A. Hoffman</b>		NAME (Type) <b>Lloyd A. Hoffman</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/5/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JAN 5 59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

# CERTIFICATE OF DEATH

STATE AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO. 100-100000

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

CAUSE OF DEATH

MANNER OF DEATH

CLERICAL

REGISTRATION

DATE

WHITE

1900

1

NOTED BY

RECORDS

1900

1900

ADDITIONAL

REMARKS

1900-1900, Mr. George Washington, 1900

DATE

PLACE

AGE

SEX

RACE

1900-1900, Mr. George Washington, 1900

1900-1900, Mr. George Washington, 1900

1179

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>MILTON</b> Last <b>DRURY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1958</b>
9. AGE (In years last birthday) yrs. <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel B. Drury</b>		14. MOTHER'S MAIDEN NAME <b>Betty Mc Carney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Daniel B. Drury</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>053.4 generalized infection</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anemia, granulocytopenia</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10, 1959</b> , to <b>Jan 15, 1959</b> , that I last saw the deceased alive on <b>Jan 15, 1959</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John D. Turco</b>		ADDRESS (Street, city or town, state) <b>302 North Potomac St</b>	
PHYSICIAN'S NAME (Type) <b>John D. Turco, M.D.</b>		DATE SIGNED <b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/18/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Berger</b>		24a. REC'D BY REGISTRAR ADDRESS <b>Hagerstown, Md.</b>	24b. REGISTRAR'S SIGNATURE <b>Jan 19 1959</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2181286XV1

CERTIFICATE OF DEATH

300

Name of Deceased		Date of Death	
John A. Smith		July 22, 1928	
Place of Birth		Place of Death	
Baltimore, Md.		Baltimore, Md.	
Age		Sex	
65		Male	
Cause of Death		Immediate Cause	
Heart Disease		Heart Disease	
Disease or Injury		Duration of Illness	
Heart Disease		Several Months	
Occupation		Signature of Physician	
Clerk		John A. Smith	
Signature of Registrar		Signature of Coroner	
John A. Smith		John A. Smith	
Date of Registration		Date of Issuance	
July 22, 1928		July 22, 1928	

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIC OR 18



1180

## CERTIFICATE OF DEATH

01183

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>4 OYEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1146 CORBETT STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SUSIE</b> Middle <b>E.</b> Last <b>DUTROW</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>10</b> Year <b>1959</b> 19			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 11 1886</b> 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OTHO J. ITNYRE</b>				14. MOTHER'S MAIDEN NAME <b>MARY SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>R.V. DUTROW</b> <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>10 yr.</b> <b>10 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 17</b> , 19 <b>49</b> , to <b>Jan. 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 5</b> , 19 <b>59</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B.B. KNEISLEY</b>				ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>B.B. KNEISLEY</b>				DATE SIGNED <b>1/12/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 13 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Best, Boonsboro, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1181

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 Weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03		d. STREET ADDRESS <u>1180 The Terrace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MERLIN</u> Middle <u>EMERY</u> Last <u>ELLINGER</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3 1896</u> 62 yrs.
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Ellinger</u>		14. MOTHER'S MAIDEN NAME <u>Alice May Marshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-9978</u>	
17. INFORMANT <u>Mrs Mildred S. Ellinger</u>		Address <u>1180 The Terrace Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Sarcoma</u> <u>200.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Reticulum Cell Sarcoma of Mesentery</u> 2 yrs - 6 mo DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug -</u> , 19 <u>56</u> , to <u>Jan. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>59</u> , and that death occurred at <u>11:00 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St.</u> DATE SIGNED <u>1-5-59</u> ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1182

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOTTIE ROW</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 24, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Orbisonia, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Row</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Book</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus; Embolus of r. brachial artery</b> 443 X DUE TO <b>Hypertensive - arteriosclerotic heart disease with auricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>8 years -</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 days -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema. Diabetes mellitus -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/25, 1938</b> , to <b>1/24, 1959</b> , that I last saw the deceased alive on <b>1/24, 1959</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington Street</b> DATE SIGNED <b>1:26:59</b>			
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.		PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b> <b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/27/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Enter-Rouzer Funeral Home</b> <b>R. Franklin Boyer</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

302

Washington

10 days

Washington County Hospital

600 Oak Hill Ave.

WHITE

SEX

JANUARY

Female

1

November 21, 1917

opposite

new book

new book

none

no

Washington

Washington

Washington

1183

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>30YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
d. STREET ADDRESS <u>1204 FAIRGROUND AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JESSE</u> First <u>JAMES</u> Middle <u>FULTON</u> Last <u>SR.</u>		4. DATE OF DEATH <u>JANUARY</u> Month <u>22</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired SHEET METAL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT MFG.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID FULTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE LEGGET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-3421</u>	
17. INFORMANT <u>MRS. CORA FULTON</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced generalized arteriosclerosis</u> <u>331X</u> DUE TO <u>Acute Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>50</u> , to <u>Jan. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 5</u> , 19 <u>59</u> , and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>1-23-59</u>	
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERN CHURCH CEM.</u>	22d. LOCATION (City, town, or county) <u>BEAVER CREEK</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Herment</u> ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1883

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF DECEASED</p> <p>14. SIGNATURE OF NEXT OF KIN</p> <p>15. SIGNATURE OF CLERGYMAN</p> <p>16. SIGNATURE OF JUDGE</p> <p>17. SIGNATURE OF SHERIFF</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF COURT</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF DECEASED</p> <p>14. SIGNATURE OF NEXT OF KIN</p> <p>15. SIGNATURE OF CLERGYMAN</p> <p>16. SIGNATURE OF JUDGE</p> <p>17. SIGNATURE OF SHERIFF</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF COURT</p>
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1184

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Convalescent Home</b>		e. STREET ADDRESS <b>934 Hamilton Boulevard</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRACE CONNER GOODELL</b>		4. DATE OF DEATH Month Day Year <b>January 29 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1873</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ravenswood, W. Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John S. Conner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kenney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mark E. Reed</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vasc. Disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 day</b> <b>8 yrs.</b> <b>8 yrs. +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec-12, 1950, to Jan 29, 1959</b> , that I last saw the deceased alive on <b>Jan 29, 1959</b> , and that death occurred at <b>11:45 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>214 N. Potomac St. 1/30/59</b>			
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/2/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Louzer Funeral Home</b> <b>B. Franklin Ruyser</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 8 Film G238 2-13-59 et

01188

1185

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>25 Mrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>33 No Locust St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MAE</b> Last <b>GRAMS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b>	9. AGE (In years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Webber</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Lee R. Grams 33 No Locust st</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>1-31-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-31-59</b> , 19 <b>59</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>1-31-59</b>							
ACTUAL SIGNATURE <b>Paul Harrison</b>				M.D. <b>318 N. Potomac St.</b>			
PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Locust Valley Fred. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

100

1999

1186

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>6 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY GIRL GRIFFITH</u>				4. DATE OF DEATH <u>JANUARY 22</u> 19 <u>59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 18 1959</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		10. UNDER 1 YEAR Months <u>4</u>		11. UNDER 24 HRS. Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN WASH. Co. MD. U.S.A.</u>			
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. Co. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LOYD S. GRIFFITH</u>				14. MOTHER'S MAIDEN NAME <u>MILDRED MARTIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>LOYD S. GRIFFITH</u>				Address <u>KEEDYSVILLE MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from _____, 19____, to <u>Jan 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>59</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.W. Helman</u> M.D.				DATE SIGNED <u>1/23/59</u>			
PHYSICIAN'S NAME (Type) <u>G.W. Helman</u>				ADDRESS <u>Boonsboro, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 24 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. BRIER CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. BRIER WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1888

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 10 1888		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		DISEASE		MEDICAL ATTENDANT		BURIAL PLACE	
1000 N. E. ST.		CLOCK MAKER		HEART DISEASE		ANGINA PECTORIS		DR. J. H. HARRIS		CATHOLIC CHURCH	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF BURIAL		NAME OF MINISTER		NAME OF CLERGYMAN	
JAN 1 1843		JAN 10 1888		10 30 AM		CATHOLIC CHURCH		FR. J. H. HARRIS		FR. J. H. HARRIS	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CLERGYMAN	
BALTIMORE, MD.		BALTIMORE, MD.		CATHOLIC CHURCH		FR. J. H. HARRIS		FR. J. H. HARRIS		FR. J. H. HARRIS	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF BURIAL		NAME OF MINISTER		NAME OF CLERGYMAN	
JAN 1 1843		JAN 10 1888		10 30 AM		CATHOLIC CHURCH		FR. J. H. HARRIS		FR. J. H. HARRIS	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CLERGYMAN	
BALTIMORE, MD.		BALTIMORE, MD.		CATHOLIC CHURCH		FR. J. H. HARRIS		FR. J. H. HARRIS		FR. J. H. HARRIS	

1187

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011.2			
c. LENGTH OF STAY IN 1b <u>1 Day</u>				d. STREET ADDRESS <u>405 Culler Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH</u> <u>GUSS</u>				4. DATE OF DEATH Month Day Year <u>January 17 1959</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan'y 16 1959</u>	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co</u>	
13. FATHER'S NAME <u>Maurice L. Guss</u>				14. MOTHER'S MAIDEN NAME <u>Florence Hasson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Maurice L. Guss 405 Culler Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia regressed membranes in mouth</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>59</u> , to <u>1/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>59</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon Jr.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>101 King St. Hagerstown Md. 1/18/59</u>			
PHYSICIAN'S NAME (Type) <u>A. M. Bacon Jr.</u>				<u>101 King St/ Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Abraham Cemetery Hagerstown Md.</u>		22d. LOCATION (City, town, or county) (State) <u>WashCo</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> 10 35 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder's Nursing Home</b>		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Heffner</b>		4. DATE OF DEATH Month <b>1</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-4-1874</b>
9. AGE (In years birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Car Repairman B.&amp;O.R.R.Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Heffner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah McKimmy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Clarence McGaha</b>	
17. INFORMANT <b>Lance, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 12</b> , 19 <b>58</b> , to <b>Jan 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>58</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. Lellan</b>		ADDRESS (Street, city or town, state) <b>Boonsboro, Md.</b>	
PHYSICIAN'S NAME (Type) <b>G. W. Lellan</b>		DATE SIGNED <b>1/5/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Burkittsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Leete</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 15 1915		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
35		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 15 1880		BALTIMORE, MARYLAND		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		Heart Disease		Natural	
RESIDENCE		DATE OF INTERMENT		PLACE OF INTERMENT	
1234 Main St, Baltimore		JAN 18 1915		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL USE	
[Signature]		[Signature]		[Stamp]	
DATE		TIME		PLACE	
JAN 15 1915		10:00 AM		BALTIMORE, MARYLAND	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF REGISTERING DEATHS IN THE STATE OF MARYLAND.

1188

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>821 W. Franklin St.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roscoe</u> Middle <u>I</u> Last <u>Hoch</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20, 1886</u>	
9. AGE (In years lost birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Piano tuner-Stieff Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry K. Hoch</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Carl Sheppard Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO <u>General arterial Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Dec 6, 1950</u> to <u>Jan 6, 1959</u> that I last saw the deceased alive on <u>Dec 16, 1957</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Wash.</u> DATE SIGNED <u>Jan 7/59</u> ACTUAL SIGNATURE <u>J A Beasley</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>J A Beasley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1189

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03/Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Carl Edward Hollis</u>		4. DATE OF DEATH <u>Jan 7 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1905</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR <u>6</u> Months <u>3</u> Days <u>3</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence J. Hollis</u>		14. MOTHER'S MAIDEN NAME <u>Hannah E. Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>McCrack Lewis Romney W. Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ruptured aneurysm</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 6</u> , 19 <u>59</u> , to <u>Jan 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>59</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		ADDRESS (Street, city or town, state) <u>136 N. Potomac</u> DATE SIGNED <u>1/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Martinsburg W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>		ADDRESS <u>Martinsburg W. Va.</u>	
24a. REC'D BY REGISTRAR <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1190

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. STREET ADDRESS <b>31 S. Prospect St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUCY</b> First <b>ANN</b> Middle <b>HOWARD</b> Last		4. DATE OF DEATH <b>January</b> Month <b>13</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR <b>11</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. J. K. Beckenbaugh</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3 Carcinoma of sigmoid with generalized abdominal extension</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks (certain)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1 1958</b> , to <b>January 13 1959</b> , that I last saw the deceased alive on <b>January 13 1959</b> , and that death occurred at <b>5:00 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 100 Professional Arts Bldg. 1/14/59</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>William T. Layman</b> PHYSICIAN'S NAME (Type) <b>William T. Layman</b> <b>Hagerstown</b> <b>Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Pouzer Funeral Home</b> <b>R. Franklin Pouzer</b>		24a. REC'D BY REGISTRAR <b>JAN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>620 Chestnut St</b>				d. STREET ADDRESS <b>620 Chestnut St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>----</b> Last <b>HUMPHREY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12 1883</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>75</b>	IF UNDER 24 HRS. Days <b>75</b> Hours <b>75</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tinsmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. M. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William T. Humphrey</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rohr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8878</b>		17. INFORMANT <b>Frank Bell Smithsburg Md. R#3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Benign Prostatic Hypertrophy</b> DUE TO (c) <b>4 years.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>---</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) <b>---</b>		(County) <b>---</b>		(State) <b>---</b>
21. I certify that I attended the deceased from <b>Jan 12 1959</b> to <b>1/13 1959</b> , that I last saw the deceased alive on <b>21st Dec 1958</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 N. BETHMAC ST. HAGERSTOWN, MARYLAND</b> DATE SIGNED <b>1/14/59</b>							
ACTUAL SIGNATURE <b>J. D. WILSON</b>		M.D. <b>J. D. WILSON, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  JOHN DOE</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  45</p>		<p>4. DATE OF BIRTH                  10-15-1910</p>	
<p>5. PLACE OF BIRTH                  Baltimore, Md.</p>		<p>6. OCCUPATION                  Clerk</p>	
<p>7. MARITAL STATUS                  Married</p>		<p>8. DATE OF DEATH                  11-1-1955</p>	
<p>9. TIME OF DEATH                  10:00 AM</p>		<p>10. PLACE OF DEATH                  Home</p>	
<p>11. CAUSE OF DEATH                  Myocardial Infarction</p>		<p>12. MANNER OF DEATH                  Natural</p>	
<p>13. SIGNATURE OF PHYSICIAN                  J. H. Smith, M.D.</p>		<p>14. SIGNATURE OF REGISTRAR                  A. B. Jones</p>	
<p>15. SIGNATURE OF DECEASED                  (If living)</p>		<p>16. SIGNATURE OF WITNESSES                  (If living)</p>	



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 EAST FIRST STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH L. HUTZELL</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 15 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 25 - 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BURKETTSVILLE FRED. CO. MD. USA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>EMORY YOUNKINS</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA RAY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or date of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>ALBA HUTZELL</u> Address <u>124 EAST 1ST STREET HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>2 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>1-14-59</u> , 19____, to <u>1-15-59</u> , 19____, that I last saw the deceased alive on <u>1-15-59</u> , 19____, and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____				22. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Harrison</u> M.D. <u>318 N. Potomac St.</u> <u>1-17-59</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>John N. Bast</u> ADDRESS <u>Beonsboro MD.</u>			
PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u> <u>Hagerstown, Md.</u>				24. REC'D BY REGISTRAR <u>JAN 20 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JAN. 18 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u>				22e. LOCATION (City, town, or county) (State) _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROWNSVILLE</b> c. LENGTH OF STAY in 1b <b>LIFE</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BROWNSVILLE MD</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROWNSVILLE</b> d. STREET ADDRESS <b>BROWNSVILLE MD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLINTON W. JENNINGS SR.</b>				4. DATE OF DEATH Month Day Year <b>JANUARY - 15 - 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY - 4 - 1881</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>BROWNSVILLE WASH. CO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOSEPH JENNINGS</b>				14. MOTHER'S MAIDEN NAME <b>NETTIE EDMUNDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-30-9765</b>		17. INFORMANT Address <b>CLINTON W. JENNINGS JR. BROWNSVILLE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V.-R disease.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-16-1959</b> , to <b>1-15-1959</b> , that I last saw the deceased alive on <b>1-15-1959</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brownsville, Md.</b> DATE SIGNED <b>1-17-59</b>							
ACTUAL SIGNATURE <b>E.E. Pruitt</b> M.D. <b>Brownsville Md.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. LUKES CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BROWNSVILLE WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bast</b> ADDRESS <b>Brownsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01198

1193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>845 Maryland Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Garrett</u> Middle <u>Lee</u> Last <u>Jessop</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-59</u>		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Jessop</u>				14. MOTHER'S MAIDEN NAME <u>Joan Routzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charles Jessop</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Malformations</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan. 9, 1959</u> to <u>Jan 9, 1959</u> , that I last saw the deceased alive on <u>10:55 p.m. Jan 9, 1959</u> , and that death occurred at <u>10:55 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> <u>Clear Spring, Maryland</u> <u>Jan. 10, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Clark</u> ADDRESS <u>Clearspring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pineda</u>	

2081201XV4



CERTIFICATE OF DEATH

1192

7-2-1914

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY REGISTRAR

NAME OF DEPUTY CLERK

NAME OF DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY REGISTRAR

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK

NAME OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK

## CERTIFICATE OF DEATH

Reg. Dist. No.

1194

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md</b>				c. LENGTH OF STAY IN 1b <b>32 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>316 N. Jonathan Street</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>			
				d. STREET ADDRESS <b>316 N. Jonathan Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Allice</b> Middle <b>Elizabeth</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 20 1890</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Berryville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Edmond Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Clifford Edwards, Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>8 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>at intervals</b>		(County) (State)	
21. I certify that I attended the deceased from <b>10/31/50</b> , 19 <b>50</b> , to <b>Jan. 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>January 5</b> , 19 <b>59</b> , and that death occurred at <b>9:05AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg. Hagerstown, Maryland</b> DATE SIGNED <b>Jan. 12-1959</b>							
ACTUAL SIGNATURE <b>William T. Layman</b>				M.D. <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman</b>				ADDRESS <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 13 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

01200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wash.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>51 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>1832 Penna. Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Indianola</b> Middle <b>Johnston</b> Last <b>Johnston</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1873</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Co., Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jonas Itneyer</b>		14. MOTHER'S MAIDEN NAME <b>Sara Wallick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Maurice S. Johnston, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo. (probably)</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7.6, 19.53</b> , to <b>1/2, 19.59</b> , that I last saw the deceased alive on <b>1/1, 19.59</b> , and that death occurred at <b>3 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>154 West Washington St., 1-3-59</b>	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 6 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-10-30

Age

Sex

Color

Religion

Married

Single

Widow

1882 Penna. Ave.

Washington County Hospital

January 2, 1930

Johnston

Johnston

Indians

Dec. 31, 1929

Female white

Washington Co., Md.

Home

Johnston

Johnston

Johnston, Johnston, Md.

None

No

*[Faint, mostly illegible text in the lower half of the form, likely containing medical history and cause of death details.]*

Johnston, Md.

Johnston, Md.

Johnston, Md.

Johnston, Md.



## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1196

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2½ Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				d. STREET ADDRESS <u>24 Winter St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>KENDLE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feby 4 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Funkstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Henry Kendle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Troupe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Lester S. Kendle 353 Devonshire Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> (c) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>15 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 19, 1958</u> , to <u>Jan 21, 1959</u> , that I last saw the deceased alive on <u>Jan 21, 1959</u> , and that death occurred at <u>4:25 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III M.D.</u>				DATE SIGNED <u>1-23-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1198

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH Jan 15, 1883	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 1, 1910	
9. NAME OF SPOUSE Mary E. Harris		10. DATE OF DEATH Dec 10, 1948	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. DISEASE OR INJURY Coronary Artery Disease		14. PERIOD OF ILLNESS Several months	
15. PLACE OF INTERMENT St. Mary's Cemetery		16. NAME OF MINISTER Rev. J. H. Smith	
17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
19. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		20. SIGNATURE OF CLERK J. H. Smith	
21. SIGNATURE OF REGISTRAR J. H. Smith		22. SIGNATURE OF JURY J. H. Smith	
23. SIGNATURE OF JURY J. H. Smith		24. SIGNATURE OF JURY J. H. Smith	
25. SIGNATURE OF JURY J. H. Smith		26. SIGNATURE OF JURY J. H. Smith	
27. SIGNATURE OF JURY J. H. Smith		28. SIGNATURE OF JURY J. H. Smith	
29. SIGNATURE OF JURY J. H. Smith		30. SIGNATURE OF JURY J. H. Smith	
31. SIGNATURE OF JURY J. H. Smith		32. SIGNATURE OF JURY J. H. Smith	
33. SIGNATURE OF JURY J. H. Smith		34. SIGNATURE OF JURY J. H. Smith	
35. SIGNATURE OF JURY J. H. Smith		36. SIGNATURE OF JURY J. H. Smith	
37. SIGNATURE OF JURY J. H. Smith		38. SIGNATURE OF JURY J. H. Smith	
39. SIGNATURE OF JURY J. H. Smith		40. SIGNATURE OF JURY J. H. Smith	
41. SIGNATURE OF JURY J. H. Smith		42. SIGNATURE OF JURY J. H. Smith	
43. SIGNATURE OF JURY J. H. Smith		44. SIGNATURE OF JURY J. H. Smith	
45. SIGNATURE OF JURY J. H. Smith		46. SIGNATURE OF JURY J. H. Smith	
47. SIGNATURE OF JURY J. H. Smith		48. SIGNATURE OF JURY J. H. Smith	
49. SIGNATURE OF JURY J. H. Smith		50. SIGNATURE OF JURY J. H. Smith	
51. SIGNATURE OF JURY J. H. Smith		52. SIGNATURE OF JURY J. H. Smith	
53. SIGNATURE OF JURY J. H. Smith		54. SIGNATURE OF JURY J. H. Smith	
55. SIGNATURE OF JURY J. H. Smith		56. SIGNATURE OF JURY J. H. Smith	
57. SIGNATURE OF JURY J. H. Smith		58. SIGNATURE OF JURY J. H. Smith	
59. SIGNATURE OF JURY J. H. Smith		60. SIGNATURE OF JURY J. H. Smith	
61. SIGNATURE OF JURY J. H. Smith		62. SIGNATURE OF JURY J. H. Smith	
63. SIGNATURE OF JURY J. H. Smith		64. SIGNATURE OF JURY J. H. Smith	
65. SIGNATURE OF JURY J. H. Smith		66. SIGNATURE OF JURY J. H. Smith	
67. SIGNATURE OF JURY J. H. Smith		68. SIGNATURE OF JURY J. H. Smith	
69. SIGNATURE OF JURY J. H. Smith		70. SIGNATURE OF JURY J. H. Smith	
71. SIGNATURE OF JURY J. H. Smith		72. SIGNATURE OF JURY J. H. Smith	
73. SIGNATURE OF JURY J. H. Smith		74. SIGNATURE OF JURY J. H. Smith	
75. SIGNATURE OF JURY J. H. Smith		76. SIGNATURE OF JURY J. H. Smith	
77. SIGNATURE OF JURY J. H. Smith		78. SIGNATURE OF JURY J. H. Smith	
79. SIGNATURE OF JURY J. H. Smith		80. SIGNATURE OF JURY J. H. Smith	
81. SIGNATURE OF JURY J. H. Smith		82. SIGNATURE OF JURY J. H. Smith	
83. SIGNATURE OF JURY J. H. Smith		84. SIGNATURE OF JURY J. H. Smith	
85. SIGNATURE OF JURY J. H. Smith		86. SIGNATURE OF JURY J. H. Smith	
87. SIGNATURE OF JURY J. H. Smith		88. SIGNATURE OF JURY J. H. Smith	
89. SIGNATURE OF JURY J. H. Smith		90. SIGNATURE OF JURY J. H. Smith	
91. SIGNATURE OF JURY J. H. Smith		92. SIGNATURE OF JURY J. H. Smith	
93. SIGNATURE OF JURY J. H. Smith		94. SIGNATURE OF JURY J. H. Smith	
95. SIGNATURE OF JURY J. H. Smith		96. SIGNATURE OF JURY J. H. Smith	
97. SIGNATURE OF JURY J. H. Smith		98. SIGNATURE OF JURY J. H. Smith	
99. SIGNATURE OF JURY J. H. Smith		100. SIGNATURE OF JURY J. H. Smith	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1247

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> c. LENGTH OF STAY IN 1b <b>SIX YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LAKIN AVENUE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>LAKIN AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROWLAND E. KEPHART</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 2 1959 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 16 1918</b>
9. AGE (in years last birthday) <b>40 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer EMPLOYED BY BUILDING CONTRACTOR MAPLEVILLE WASH.CO.MD.U.S.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ELMER A. KEPHART</b>		14. MOTHER'S MAIDEN NAME <b>ETHEL KEADLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES WORLD WAR 2</b>		16. SOCIAL SECURITY NO. <b>220 16 3990</b>	
17. INFORMANT <b>MRS. DEVONA KEPHART BOONSBORO MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Vascular Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JANUARY 5 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY BOONSBORO WASH.CO.MD.</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bad Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

STATE OF  
NEW YORK

OFFICE OF THE  
ATTORNEY GENERAL  
ALBANY, N. Y.

1911

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1197

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. STREET ADDRESS <b>1009 woodland Way</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARA ELIZABETH KING</b>				4. DATE OF DEATH Month Day Year <b>January 11 1959 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27 1895</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pa Greencastle Franklin Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fray A. Goetz</b>				14. MOTHER'S MAIDEN NAME <b>Annie Burtman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Harry G. King 1009 Woodland Way</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal carcinomatosis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>about 2 1/2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 8, 1939</b> , to <b>Jan. 11, 1959</b> , that I last saw the deceased alive on <b>Jan. 11, 1959</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>1:12:59</b>							
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		M.D. <b>John H. Hornbaker, M.D.</b>		ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b>		DATE SIGNED <b>1:12:59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. RECEIVED BY REGISTRAR DATE <b>JAN 16 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	
CERTIFICATE OF DEATH [REDACTED]		[REDACTED]	

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 19[REDACTED].  
 [REDACTED]  
 REGISTRAR

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>ONE WEEK</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X ROHRERSVILLE</b> d. STREET ADDRESS <b>ROHRERSVILLE MD.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDITH I. KNADLER</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 11 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 5, 1880</b>
9. AGE (In years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>LOCUST GROVE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LORENZO Q. ROHRER</b>		14. MOTHER'S MAIDEN NAME <b>MARY SHIFLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-9876</b>	
17. INFORMANT <b>MRS. LLOYD MULLENDORE</b>		Address <b>ROHRERSVILLE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>904.0</b> DUE TO <b>Arteriosclerotic Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured Left Hip</b> DUE TO (c) <b>Interval BETWEEN ONSET AND DEATH</b> <b>5 yrs</b> <b>2 wks</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Christmas day - fell in kitchen</b>	
20c. TIME OF INJURY Month, Day, Year Hour or m. p. m. <b>1 Dec. 25, 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rorersville Washington Md</b>	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>59</b> , to <b>Jan 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 10</b> , 19 <b>59</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> DATE SIGNED <b>1/12/59</b> ACTUAL SIGNATURE <b>G. W. He Van</b> PHYSICIAN'S NAME (Type) <b>G. W. He Van</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 14 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOCUST GROVE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>LOCUST GROVE WASH. CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Burt</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1248

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stouffer Ave</u>				e. STREET ADDRESS <u>Stouffer Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>PAUL</u> Last <u>KNIPE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publishing Co Prior Co</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Sharpsburg Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hamilton L. Knipe</u>				14. MOTHER'S MAIDEN NAME <u>Sally Leymaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 1 217-12-1962</u>		17. INFORMANT <u>Mrs Grace McD Knipe</u> Address <u>Stouffer Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>ADENOCARCINOMA OF HEAD OF PANCREAS WITH METASTASIS TO LIVER</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7, 1958</u> to <u>Jan. 16, 1959</u> , that I last saw the deceased alive on <u>Jan. 16, 1959</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Kehne</u>				ADDRESS (Street, city or town, state) <u>131 W. Washington St.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>John H. Kehne, M. D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>W. Va.</u> (State) <u>Berkley Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 301

1249

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL (If not in-hospital, give street address) OR INSTITUTION <b>Homewood Church Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Delaware</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ehester</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NANNIE LOPP LEONARD</b>				4. DATE OF DEATH Month Day Year <b>January 21 1959 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 16 1884</b>	
9. AGE (In years last birthday) <b>74</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Davidson Co No Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Mathias Lopp</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Jane Burkhart</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>Mrs Paul Aley 216 West Brookhaven Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic cardiac degeneration</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-16, 1958</b> , to <b>1-21, 1959</b> , that I last saw the deceased alive on <b>1-16-59</b> , 19, and that death occurred at <b>PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. E. W. Dittig</i>				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>			
PHYSICIAN'S NAME (Type) <b>J. E. W. Dittig</b>				DATE SIGNED <b>1/27/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pilgrim Ref. Cemetery Lexington No Carolina</b>		22d. LOCATION (City, town, or county) (State) <b>R # 1</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Charles L. Tinsdale</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

DATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. ROBERTS</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. RACE <b>WHITE</b>	
5. PLACE OF BIRTH <b>BALTIMORE, MARYLAND</b>		6. DATE OF BIRTH <b>1918</b>		7. PLACE OF DEATH <b>BALTIMORE, MARYLAND</b>		8. DATE OF DEATH <b>1963</b>	
9. OCCUPATION <b>LABORER</b>		10. CAUSE OF DEATH <b>HEART DISEASE</b>		11. MANNER OF DEATH <b>NATURAL</b>		12. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
13. SIGNATURE OF REGISTRAR <b>[Signature]</b>		14. SIGNATURE OF WITNESS <b>[Signature]</b>		15. SIGNATURE OF DECEASED <b>[Signature]</b>		16. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
17. SIGNATURE OF DECEASED <b>[Signature]</b>		18. SIGNATURE OF SURVIVOR <b>[Signature]</b>		19. SIGNATURE OF DECEASED <b>[Signature]</b>		20. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
21. SIGNATURE OF DECEASED <b>[Signature]</b>		22. SIGNATURE OF SURVIVOR <b>[Signature]</b>		23. SIGNATURE OF DECEASED <b>[Signature]</b>		24. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
25. SIGNATURE OF DECEASED <b>[Signature]</b>		26. SIGNATURE OF SURVIVOR <b>[Signature]</b>		27. SIGNATURE OF DECEASED <b>[Signature]</b>		28. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
29. SIGNATURE OF DECEASED <b>[Signature]</b>		30. SIGNATURE OF SURVIVOR <b>[Signature]</b>		31. SIGNATURE OF DECEASED <b>[Signature]</b>		32. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
33. SIGNATURE OF DECEASED <b>[Signature]</b>		34. SIGNATURE OF SURVIVOR <b>[Signature]</b>		35. SIGNATURE OF DECEASED <b>[Signature]</b>		36. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
37. SIGNATURE OF DECEASED <b>[Signature]</b>		38. SIGNATURE OF SURVIVOR <b>[Signature]</b>		39. SIGNATURE OF DECEASED <b>[Signature]</b>		40. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
41. SIGNATURE OF DECEASED <b>[Signature]</b>		42. SIGNATURE OF SURVIVOR <b>[Signature]</b>		43. SIGNATURE OF DECEASED <b>[Signature]</b>		44. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
45. SIGNATURE OF DECEASED <b>[Signature]</b>		46. SIGNATURE OF SURVIVOR <b>[Signature]</b>		47. SIGNATURE OF DECEASED <b>[Signature]</b>		48. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
49. SIGNATURE OF DECEASED <b>[Signature]</b>		50. SIGNATURE OF SURVIVOR <b>[Signature]</b>		51. SIGNATURE OF DECEASED <b>[Signature]</b>		52. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
53. SIGNATURE OF DECEASED <b>[Signature]</b>		54. SIGNATURE OF SURVIVOR <b>[Signature]</b>		55. SIGNATURE OF DECEASED <b>[Signature]</b>		56. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
57. SIGNATURE OF DECEASED <b>[Signature]</b>		58. SIGNATURE OF SURVIVOR <b>[Signature]</b>		59. SIGNATURE OF DECEASED <b>[Signature]</b>		60. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
61. SIGNATURE OF DECEASED <b>[Signature]</b>		62. SIGNATURE OF SURVIVOR <b>[Signature]</b>		63. SIGNATURE OF DECEASED <b>[Signature]</b>		64. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
65. SIGNATURE OF DECEASED <b>[Signature]</b>		66. SIGNATURE OF SURVIVOR <b>[Signature]</b>		67. SIGNATURE OF DECEASED <b>[Signature]</b>		68. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
69. SIGNATURE OF DECEASED <b>[Signature]</b>		70. SIGNATURE OF SURVIVOR <b>[Signature]</b>		71. SIGNATURE OF DECEASED <b>[Signature]</b>		72. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
73. SIGNATURE OF DECEASED <b>[Signature]</b>		74. SIGNATURE OF SURVIVOR <b>[Signature]</b>		75. SIGNATURE OF DECEASED <b>[Signature]</b>		76. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
77. SIGNATURE OF DECEASED <b>[Signature]</b>		78. SIGNATURE OF SURVIVOR <b>[Signature]</b>		79. SIGNATURE OF DECEASED <b>[Signature]</b>		80. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
81. SIGNATURE OF DECEASED <b>[Signature]</b>		82. SIGNATURE OF SURVIVOR <b>[Signature]</b>		83. SIGNATURE OF DECEASED <b>[Signature]</b>		84. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
85. SIGNATURE OF DECEASED <b>[Signature]</b>		86. SIGNATURE OF SURVIVOR <b>[Signature]</b>		87. SIGNATURE OF DECEASED <b>[Signature]</b>		88. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
89. SIGNATURE OF DECEASED <b>[Signature]</b>		90. SIGNATURE OF SURVIVOR <b>[Signature]</b>		91. SIGNATURE OF DECEASED <b>[Signature]</b>		92. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
93. SIGNATURE OF DECEASED <b>[Signature]</b>		94. SIGNATURE OF SURVIVOR <b>[Signature]</b>		95. SIGNATURE OF DECEASED <b>[Signature]</b>		96. SIGNATURE OF SURVIVOR <b>[Signature]</b>	
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1199

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		c. LENGTH OF STAY IN 1b <b>60 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>25 W. North Street</b>	
3. NAME OF DECEASED (Type or print) <b>Mortimer</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1 1881</b>
9. AGE (In years last birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Servant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (State or foreign country) <b>Rappahannock, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Henry Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Rissa William</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-7670</b>	
17. INFORMANT <b>Isabella Lewis</b>		Address <b>25 W. North Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic</b> DUE TO (c) <b>trophic ulcer - R leg</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>1 yr.</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>57</b> , to <b>Aug 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 20</b> , 19 <b>59</b> , and that death occurred at <b>7:00</b> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>159 W. Washington St. Hagerstown, Md. 2/2/59</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 2 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md</b>		24a. REC'D BY REGISTRAR <b>DATE 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1875		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 15, 1920		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
1875		1920		1875		1920		1875		1920	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
1875		1920		1875		1920		1875		1920	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
1875		1920		1875		1920		1875		1920	

CERTIFICATE OF DEATH

1. Name of deceased  
2. Age  
3. Sex  
4. Race  
5. Date of birth  
6. Place of birth  
7. Residence  
8. Occupation  
9. Cause of death  
10. Manner of death  
11. Date of death  
12. Place of death  
13. Father  
14. Mother  
15. Spouse  
16. Children  
17. Education  
18. Religion  
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100. DIED

1200

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBINA</b> First <b>MARIE</b> Middle <b>MARKEY</b> Last		4. DATE OF DEATH <b>January 15 1959</b> Month <b>January</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 14, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Albany, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Maximilian La Liberte</b>		14. MOTHER'S MAIDEN NAME <b>Ablina Dutrizac</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-30-9666</b>	
17. INFORMANT <b>Mrs. Lorena Toth</b>		Address <b>Baltimore, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis &amp; Hypertension Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 yrs.</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 2, 1958</b> , to <b>Jan 15, 1959</b> , that I last saw the deceased alive on <b>Jan 14, 1959</b> , and that death occurred at <b>1:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b> DATE SIGNED <b>1/16/59</b>			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		M.D. <b>Philip J. Hirshman, M.D.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/19/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

100

<p>1. Name of deceased                  ALFRED J. BROWN</p>		<p>2. Sex                  Male</p>	
<p>3. Date of birth                  January 1, 1890</p>		<p>4. Place of birth                  New York, U.S.A.</p>	
<p>5. Date of death                  December 1, 1960</p>		<p>6. Place of death                  New York, U.S.A.</p>	
<p>7. Cause of death                  Heart disease</p>		<p>8. Manner of death                  Natural</p>	
<p>9. Signature of physician                  J. H. Smith, M.D.</p>		<p>10. Signature of registrar                  J. H. Smith, M.D.</p>	
<p>11. Date of registration                  December 1, 1960</p>		<p>12. Place of registration                  New York, U.S.A.</p>	

1201  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown R#5</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Hagerstown R # 5 Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>MAE</b> Last <b>MARTIN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1878</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR: Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Shanks, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacobs Ganoe</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hines</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Shrivey E. Martin</b>		Address <b>R # 5 Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Superior mesenteric venous thrombosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-2</b> , 19 <b>58</b> , to <b>1-31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-31</b> , 19 <b>59</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>2-2-59</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b>		M.D. <b>Smithsburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b> <b>Charles F. Hess M.D. Smithsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Methodist Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>2 mi. E. Romney W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE B 3 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hess</b>

*Wm. G. Host o-Proc.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1202

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>VICTORIA</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1886</b>		9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Bunker Hill W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth Tapp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. John R. Ward R#2 Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 5, 1959</b> , to <b>January 16, 1959</b> that I last saw the deceased alive on <b>January 15, 1959</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 North Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>1/17/59</b> ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b> PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D. Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>January 19, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 20 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. G. Host O-Proc.

11918

## MAKALAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		38		JAN 15 1910	
CITY OF DEATH		COUNTY		STATE		COUNTRY	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		HOUR		MINUTE		SECOND	
JAN 18 1948		10		15		00	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
RESIDENT		OCCUPATION		EDUCATION		RELIGION	
BALTIMORE		LABORER		HIGH SCHOOL		METHODIST	
MARRIED		SINGLE		WIDOWED		DIVORCED	
YES		NO		YES		NO	
NAME OF SPOUSE		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF MARRIAGE	
JANE HARRIS		JAN 15 1910		JANE HARRIS		JAN 15 1910	
NAME OF NEXT OF KIN		ADDRESS		CITY		STATE	
JOHN HARRIS		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF PHYSICIAN		ADDRESS		CITY		STATE	
DR. J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF BURIAL PLACE		ADDRESS		CITY		STATE	
GREENWOOD CEMETERY		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF FUNERAL HOME		ADDRESS		CITY		STATE	
HARRIS FUNERAL HOME		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF MINISTER		ADDRESS		CITY		STATE	
PASTOR J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF CHURCH		ADDRESS		CITY		STATE	
METHODIST CHURCH		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF CLERGYMAN		ADDRESS		CITY		STATE	
PASTOR J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MARYLAND	
NAME OF CLERGYMAN		ADDRESS		CITY		STATE	
PASTOR J. H. HARRIS		1234 E. BALTIMORE		BALTIMORE		MARYLAND	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND HUMAN SERVICES. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT OR ANY OTHER AGENCY.

MAKALAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11918



1250

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna</b> COUNTY <b>York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c. LENGTH OF STAY IN TB <b>7 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood church Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>York</b> <b>75x.3</b>			
f. STREET ADDRESS <b>Queen And Market sts</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>E</b> Last <b>McELROY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 29 1876</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>York York Co Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George McElroy</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT Address <b>Rev Mark Wagner Homewood Church Home</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> (c) <b>Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-20</b> , 19 <b>58</b> , to <b>1-12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-11</b> , 19 <b>59</b> , and that death occurred at <b>3X</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. F. W. Hitt</b>				DATE SIGNED <b>1/12/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>York York Co Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1203

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>20 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro. R#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>Bakersville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Cromartie</b> Last <b>McNeill</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1890 ?</b>	9. AGE (In years lost birthday) <b>78 ?</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Road Equipment</b>		11. BIRTHPLACE (State and foreign country) <b>Charleston Co. S. Car.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Donald T. McNeill</b>				14. MOTHER'S MAIDEN NAME <b>Mary E Cromartie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Elizebeth Price</b>		Address <b>Hagerstown, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <b>19</b> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>12-30</b> , 19 <b>58</b> , to <b>1-18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-18</b> , 19 <b>59</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>28 W Potomac</b> DATE SIGNED <b>1-20-59</b> ACTUAL SIGNATURE <b>M E Burkett</b> M.D. <b>Williamport Md</b> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Luthern Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bakersville, Md. Wash. Co</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01213

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>24 Cypress Street</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>RUDOLPH</b> Middle <b>MILLER</b> Last		4. DATE OF DEATH <b>January 15 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Dealer</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Hill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-3692</b>	
17. INFORMANT <b>Mrs. Elizabeth Miller</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/19/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

no. 1000

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Signature: \_\_\_\_\_

2000

70124, 0 052007

CCRP-00-179

7. The following is a list of the names of the persons who have been named in the above mentioned affidavits as having been in the possession of the same at the time of the same being made:

615

60-71-529

5-15-60

133163

### III. Results

4-10-12

[illegible]

referred to as



1205  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1002 Salem Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b> First <b>GERTRUDE</b> Middle <b>MILLER</b> Last		4. DATE OF DEATH <b>January 26 1959</b> 19 <b>19</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel Hill</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Snyder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George C. Miller</b> Address <b>1002 Salem Ave Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Periarteritis Nodosa.</b> <b>456x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 28, 1958</b> , to <b>Jan. 26, 1959</b> , that I last saw the deceased alive on <b>January 25, 1959</b> and that death occurred at <b>7:15AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.A. Bell</b>		ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		DATE SIGNED <b>1-27-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 29 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. K.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01215

1206

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2114 1/2 Virginia Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth First Middle Last Jennings Minnebraker</b>		4. DATE OF DEATH <b>January 17 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. a.</b>	
13. FATHER'S NAME <b>Jacob Le Fevre</b>		14. MOTHER'S MAIDEN NAME <b>ISadora Feigley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Evers Berger</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. f. i. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/17/58</b> to <b>1/17/59</b> , that I last saw the deceased alive on <b>1/17/59</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D.		ADDRESS (Street, city or town, state) <b>101 E. Potomac St.</b>	
PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>		City <b>Williamsport Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown d.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

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## THE PROGRAMMING

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Scott W. Hamilton & Son

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool R # 1</b>				c. LENGTH OF STAY IN 1b <b>1 Yr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ft Frederick Road</b>				e. STREET ADDRESS <b>Ft Frederick Road</b>			
3. NAME OF DECEASED (Type or print) First <b>HUBERT</b> Middle <b>( HUGH )</b> Last <b>BOOTH MONGAN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20 1883</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Tilghmanton Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hezekiah Mongan</b>				14. MOTHER'S MAIDEN NAME <b>Alice Daugherty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-2007</b>		17. INFORMANT <b>Mrs Hazel Hafer Mongan Big Pool Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>May 30</b> , 19 <b>58</b> , to <b>Jan. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>December 22</b> , 19 <b>58</b> , and that death occurred at <b>5:55 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Archie Robert Cohen</i>		M.D. _____					
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		<b>Clear Spring, Maryland</b>		<b>Jan. 9, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery Hagerstown Wash. Co Md.</b>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



1207

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. STREET ADDRESS <b>132 North Mulberry</b>	
3. NAME OF DECEASED (Type or print) <b>Francine Lisa Mowery</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1958</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Mowery</b>		14. MOTHER'S MAIDEN NAME <b>Beverly Parlette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Richard Mowery</b>		Address <b>Hagerstown, 132 N. Mulberry</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>BRONCHOPNEUMONIA, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/24</b> , 19 <b>59</b> , to <b>1/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/28/59</b> , 19 <b>59</b> , and that death occurred at <b>12:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard A. Young</b>		ADDRESS (Street, city or town, and state) <b>101 King Street - Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Richard A. Young</b>		DATE SIGNED <b>1/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shanktown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shanktown, Wash. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF INTERVIEW

INTERVIEWER

WITNESSES

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01218

Reg. Dist. No.

1208

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>North St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>MANSFIELD</u> Last <u>MULLENIX</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Capland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Alfred Mullenix</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Corder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-6565</u>		17. INFORMANT <u>Mrs. C.M. Mullenix</u> Address <u>North St. Maugansville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fracture pelvic bones</u> <u>812X</u> DUE TO <u>Hemorrhage and shock</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stepped in front of moving auto</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:15</u> <u>xxx</u> <u>Jan. 5 19 59</u> Hour <u>  </u> o. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rural Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Manner of Death: \_\_\_\_\_

9. Signature of Medical Examiner: \_\_\_\_\_

10. Date: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Registrar: \_\_\_\_\_

13. Signature of Physician: \_\_\_\_\_

14. Signature of Nurse: \_\_\_\_\_

15. Signature of Undertaker: \_\_\_\_\_

16. Signature of Burial Place: \_\_\_\_\_

17. Signature of Funeral Home: \_\_\_\_\_

18. Signature of Cemetery: \_\_\_\_\_

19. Signature of Interment: \_\_\_\_\_

20. Signature of Burial: \_\_\_\_\_

21. Signature of Cremation: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

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98. Signature of Other: \_\_\_\_\_

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100. Signature of Other: \_\_\_\_\_

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 16 yrs.		d. STREET ADDRESS 1115 Corbett St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1115 Corbett St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES LEWIS MULLIGAN		4. DATE OF DEATH January 18 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1910
9. AGE (in years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Dickerson, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry E. Mulligan		14. MOTHER'S MAIDEN NAME Cora E. Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-7837	
17. INFORMANT Mrs. C. L. Mulligan		Address 1115 Corbett St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gun shot into skull and brain tissue DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 22 calibre thru skull	
20c. TIME OF INJURY Month, Day, Year 8:30 p.m. Jan. 18 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Hagerstown (County) Wash (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 21 1959	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

Wm. C. Howard C-1115





## 1252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 mos. 2 wks 1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C.</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 9 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Myers</u>				14. MOTHER'S MAIDEN NAME <u>Martha Crider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>J. Howard Myers</u> Address <u>Charleston W. Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>58</u> , to <u>Jan 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Hark</u>				M.D. <u>RFD #2</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HARK</u>				ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>1/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Martinsburg W. Va</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>				ADDRESS <u>Martinsburg</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneak</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1253 CERTIFICATE OF DEATH

Reg. Dist. No.

01221

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>THREE MONTHS</b> <b>X BOONSBORO</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REEDER NURSING HOME</b>				d. STREET ADDRESS <b>WINDY ACRES</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH J. NORTON</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 3 1959 19</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1876</b> <b>JULY 11 1875</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MEYERSDALE PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES VATCHER JACOBS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH KREITZBERG</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. J. HOWARD BECKENBAUGH BOONSBORO MD</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decompensation of heart</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>18 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 90</b> , 19 <b>58</b> , to <b>Jan 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>59</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md</b> DATE SIGNED <b>1/5/59</b> ACTUAL SIGNATURE <b>G. W. Lelan</b> M.D. PHYSICIAN'S NAME (Type) <b>G. W. Lelan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 6 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEMORIAL CEMETERY FROSTBURG MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Bass</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1254

CERTIFICATE OF DEATH

01222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>14 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Conv. Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Hagerstown</b>			
				f. STREET ADDRESS <b>Hagerstown #4</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Byers</b> Last <b>Patterson</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/1901</b>	
				9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn Brook Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Rev. John Edward Byers D.D.</b>				14. MOTHER'S MAIDEN NAME <b>Virtue E. Hoover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daniel Byers, Waynesboro Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.1</b> <b>Leukemia of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Alcohol</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 31, 1958</b> , to <b>January 14, 1959</b> , that I last saw the deceased alive on <b>January 13, 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> DATE SIGNED <b>1/14/59</b> ACTUAL SIGNATURE <b>G. W. H. Van</b> M.D. <b>Boonsboro Md.</b> PHYSICIAN'S NAME (Type) <b>G. W. H. Van</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Grove, Waynesboro Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 16 59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert A. Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIANND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1210

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>LAVINIA</b> Last <b>PAYNE</b>			4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1884</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Near Clearspring, Md.</b>
13. FATHER'S NAME <b>Samuel Mummert</b>			14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth Beard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Chester Metcalf Mercersburg, Penn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs.</b> <b>12 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 3, 1944</b> , to <b>1-12, 1959</b> , that I last saw the deceased alive on <b>1-12, 1959</b> , and that death occurred at <b>7:00 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert P. Conrad</b>		ADDRESS (Street, city or town, state) <b>13700 Washington</b>		DATE SIGNED <b>1-13-59</b>	
PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	
22d. LOCATION (City, town, or county) <b>St. Paul's</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rouser</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 16 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Rous</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

300

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		New York City		10:00 AM		[Signature]		[Signature]	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1945		10:00 AM		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
Jan 10, 1945		10:00 AM		New York City		Heart Disease		New York City		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
BUREAU OF VITALS  
JAN 15 1945

1211

## CERTIFICATE OF DEATH

01224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>20 HOURS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BOONSBORO RURAL</b> d. STREET ADDRESS <b>ROUTE 40A EAST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA E. RENNER</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 10 1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 7 1873</b>	9. AGE (In years last birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALLEN LINE</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE CATHERINE ALBAUGH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>RICHARD L. RENNER SR. BOONSBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Intracerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Anoxia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Jan 9</b> , 19 <b>59</b> , to <b>Jan 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 10</b> , 19 <b>59</b> , and that death occurred at <b>11:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sidney Novenstein M.D. Boonsboro Md 1/12/59</b>							
ACTUAL SIGNATURE <b>SIDNEY NOVENSTEIN</b>		PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 13 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH.CO.MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East Boonsboro Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 14 59</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE		PLACE OF BIRTH	
JAMES H. HARRIS		MARRIED		NEW YORK	
DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1890		JAN 10 1950		BALTIMORE, MD.	
AGE		SEX		RACE	
60		M		W	
OCCUPATION		EDUCATION		RELIGION	
CLOCK REPAIRER		HIGH SCHOOL		METHODIST	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
CORONARY THROMBOSIS		NATURAL		CATHOLIC CEMETERY	
DATE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
JAN 12 1950		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND THE MARYLAND BOARD OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND BOARD OF HEALTH IF IT IS NOT SIGNED BY A MEMBER OF THE BOARD OF HEALTH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G238 1-23-59 et

CERTIFICATE OF DEATH

01225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>		10x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		d. STREET ADDRESS	
e. 15. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Christine</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1877</b>
9. AGE (In years birth day) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Schwartz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Benne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Earl A. Rice, Jr.</b>		Address <b>Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> (c) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>67m</b> <b>54m</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-13-59</b> , to <b>1-16-59</b> , that I last saw the deceased alive on <b>1-16-59</b> , 19 <b>59</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>1/17/59</b> ACTUAL SIGNATURE <b>R. E. Creager</b> M.D. <b>Hagerstown Md</b> PHYSICIAN'S NAME (Type) <b>R. E. Creager</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewistown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

Washington

Ena Lyra M.

1998

2740

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Lowiston Cemetery

Low'stown Maryland

Raymond E. Creeger, Chairman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01226

1213

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>412 N. Mulberry</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Daniel Rice</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1903</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairground</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James W. Rice</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Schroud</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Doris Angstat</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure, marked</b> <b>411X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic stenosis (? rheumatic)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>about 3 wks</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-9, 1959</b> , to <b>1-11, 1959</b> , that I last saw the deceased alive on <b>1-11, 1959</b> , and that death occurred at <b>12 Noon</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		ADDRESS (Street, city or town, state) <b>154 W. Washington St.</b>	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker</b>		DATE SIGNED <b>1-14-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

CERTIFICATE OF DEATH

Name of Deceased Scott E. Linnick & Son Laketown Md.		Date of Death 1-13-34		Place of Death Laketown Md.	
Name of Informant John H. Hornbaker Laketown Md.		Relationship of Informant to Deceased Brother		Address of Informant 128 W. Washington St. Washington D.C.	
Name of Deceased James W. Linnick Laketown Md.		Date of Death February 21, 1903		Place of Death Laketown Md.	
Name of Informant U. Royal Linnick Laketown Md.		Relationship of Informant to Deceased Son		Address of Informant Laketown Md.	
Name of Deceased William Daniel Rice Laketown Md.		Date of Death January 11, 1933		Place of Death Laketown Md.	
Name of Informant A. H. W. Linnick Laketown Md.		Relationship of Informant to Deceased Son		Address of Informant Laketown Md.	
Name of Deceased Boris Angarat Laketown Md.		Date of Death February 21, 1903		Place of Death Laketown Md.	
Name of Informant Minnie Schonek Laketown Md.		Relationship of Informant to Deceased Daughter		Address of Informant Laketown Md.	
Name of Deceased U. Royal Linnick Laketown Md.		Date of Death February 21, 1903		Place of Death Laketown Md.	
Name of Informant James W. Linnick Laketown Md.		Relationship of Informant to Deceased Son		Address of Informant Laketown Md.	
Name of Deceased William Daniel Rice Laketown Md.		Date of Death January 11, 1933		Place of Death Laketown Md.	
Name of Informant A. H. W. Linnick Laketown Md.		Relationship of Informant to Deceased Son		Address of Informant Laketown Md.	
Name of Deceased Boris Angarat Laketown Md.		Date of Death February 21, 1903		Place of Death Laketown Md.	
Name of Informant Minnie Schonek Laketown Md.		Relationship of Informant to Deceased Daughter		Address of Informant Laketown Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01227

1214

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>216 N. Cannon Ave.</b>				d. STREET ADDRESS <b>216 N. Cannon Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Roscoe</b> Last <b>Rider</b>			4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1896</b>		9. AGE (In years last birthday) <b>62 yrs</b>	IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Hancock, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Thomas Rider</b>				14. MOTHER'S MAIDEN NAME <b>Frances Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. # 1 214-09-2955</b>		17. INFORMANT <b>Mrs. Roy Rider, 216 N. Cannon Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral <del>arterio-sclerotic</del> Arterio-sclerotic</b> DUE TO (c) <b>SCIEROTIC</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>4 1/2 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>1-26-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-26-59</b> , 19 <b>59</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>1-27-59</b>							
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.				PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 1959</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF MEDICAL OFFICER		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF BURIAL OFFICER		14. SIGNATURE OF FUNERAL DIRECTOR		15. SIGNATURE OF CHURCH OFFICER	
16. SIGNATURE OF CEMETERY OFFICER		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWEE	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWEE		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

1255

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conococheague Md.</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convelescent Home Inc.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>0102-2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Miller</u> Last <u>Rinehart</u>		d. STREET ADDRESS <u>105 Park Street</u>	
4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1959</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint &amp; Glass</u>	
11. BIRTHPLACE (State or foreign country) <u>Greencastle Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Rinehart</u>		14. MOTHER'S MAIDEN NAME <u>Sally Foltz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-7619</u>	
17. INFORMANT <u>Mrs. Julia Newman</u>		Address <u>Cumberland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chrs. Cardiac Failure</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u></u> Year <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>Jan 8</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>59</u> , and that death occurred at <u>8:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		DATE SIGNED <u>1/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport Md</u>		ADDRESS <u>Williamsport Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01229

1215

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1975 Jefferson Blvd</u>		d. STREET ADDRESS <u>1975 Jefferson Blvd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE GERTRUDE EARNSHAW-RITTER</u>		4. DATE OF DEATH Month Day Year <u>January 22 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25 1883</u>
9. AGE (In years last birthday) <u>75 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>Staunton Augusta Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Luther Lilley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-3323</u>	
17. INFORMANT <u>Mrs Phoebe Huntzberry</u>		Address <u>1975 Jefferson Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular hypertension</u> <u>900.0</u> DUE TO <u>Generalized advanced Rheumatoid arthritis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fractured skull</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down the cellar stairs in home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10:45</u> <u>Jan. 22 19 59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>1-23-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '59</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hous</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



DATE  
TIME

PLACE TO BE  
EXAMINED

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

## 1216 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural 2 Hancock Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rickie</u> Middle <u>Lee</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.7.57</u>
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Doyle Reed</u>		14. MOTHER'S MAIDEN NAME <u>Dolly Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dolly Divelbliss Sr.</u>		Address <u>Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured esophageal vein</u> 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforation of Meckel's diverticulum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/20</u> , 19 <u>58</u> , to <u>1/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>59</u> , and that death occurred at <u>6:24</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Richard A. Young</u> M.D. <u>101 KING STREET</u> PHYSICIAN'S NAME (Type) <u>Richard A. Young</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1.7.58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Moore Hancock Md.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01231

1217

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>48 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 Fairground Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Alice</b> Last <b>Routzahn</b>		4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1876</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homeduties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Middletown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zachary Firestone</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BRANDENBERG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Hazel Snively</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease and</b> DUE TO <b>coronary arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>Indefinite</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1959</b> to <b>Jan. 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan. 18</b> , 19 <b>59</b> , and that death occurred at <b>5 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Maryland</b> DATE SIGNED <b>1/21/59</b>			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		M.D. <b>148 West Washington St. Hagerstown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>burial</b>	<b>1-23-59</b>	<b>Rose Hill</b>	<b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 26 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraiss</b>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Immediate cause: _____</p>		<p>9. Underlying cause: _____</p>	
<p>10. Manner of death: _____</p>		<p>11. Signature of physician: _____</p>		<p>12. Signature of registrar: _____</p>	
<p>13. Date of registration: _____</p>		<p>14. Registrar's name: _____</p>		<p>15. Registrar's address: _____</p>	
<p>16. Registrar's phone: _____</p>		<p>17. Registrar's fax: _____</p>		<p>18. Registrar's email: _____</p>	
<p>19. Registrar's title: _____</p>		<p>20. Registrar's department: _____</p>		<p>21. Registrar's division: _____</p>	
<p>22. Registrar's office: _____</p>		<p>23. Registrar's room: _____</p>		<p>24. Registrar's box: _____</p>	
<p>25. Registrar's phone: _____</p>		<p>26. Registrar's fax: _____</p>		<p>27. Registrar's email: _____</p>	
<p>28. Registrar's title: _____</p>		<p>29. Registrar's department: _____</p>		<p>30. Registrar's division: _____</p>	
<p>31. Registrar's office: _____</p>		<p>32. Registrar's room: _____</p>		<p>33. Registrar's box: _____</p>	
<p>34. Registrar's phone: _____</p>		<p>35. Registrar's fax: _____</p>		<p>36. Registrar's email: _____</p>	
<p>37. Registrar's title: _____</p>		<p>38. Registrar's department: _____</p>		<p>39. Registrar's division: _____</p>	
<p>40. Registrar's office: _____</p>		<p>41. Registrar's room: _____</p>		<p>42. Registrar's box: _____</p>	
<p>43. Registrar's phone: _____</p>		<p>44. Registrar's fax: _____</p>		<p>45. Registrar's email: _____</p>	
<p>46. Registrar's title: _____</p>		<p>47. Registrar's department: _____</p>		<p>48. Registrar's division: _____</p>	
<p>49. Registrar's office: _____</p>		<p>50. Registrar's room: _____</p>		<p>51. Registrar's box: _____</p>	
<p>52. Registrar's phone: _____</p>		<p>53. Registrar's fax: _____</p>		<p>54. Registrar's email: _____</p>	
<p>55. Registrar's title: _____</p>		<p>56. Registrar's department: _____</p>		<p>57. Registrar's division: _____</p>	
<p>58. Registrar's office: _____</p>		<p>59. Registrar's room: _____</p>		<p>60. Registrar's box: _____</p>	
<p>61. Registrar's phone: _____</p>		<p>62. Registrar's fax: _____</p>		<p>63. Registrar's email: _____</p>	
<p>64. Registrar's title: _____</p>		<p>65. Registrar's department: _____</p>		<p>66. Registrar's division: _____</p>	
<p>67. Registrar's office: _____</p>		<p>68. Registrar's room: _____</p>		<p>69. Registrar's box: _____</p>	
<p>70. Registrar's phone: _____</p>		<p>71. Registrar's fax: _____</p>		<p>72. Registrar's email: _____</p>	
<p>73. Registrar's title: _____</p>		<p>74. Registrar's department: _____</p>		<p>75. Registrar's division: _____</p>	
<p>76. Registrar's office: _____</p>		<p>77. Registrar's room: _____</p>		<p>78. Registrar's box: _____</p>	
<p>79. Registrar's phone: _____</p>		<p>80. Registrar's fax: _____</p>		<p>81. Registrar's email: _____</p>	
<p>82. Registrar's title: _____</p>		<p>83. Registrar's department: _____</p>		<p>84. Registrar's division: _____</p>	
<p>85. Registrar's office: _____</p>		<p>86. Registrar's room: _____</p>		<p>87. Registrar's box: _____</p>	
<p>88. Registrar's phone: _____</p>		<p>89. Registrar's fax: _____</p>		<p>90. Registrar's email: _____</p>	
<p>91. Registrar's title: _____</p>		<p>92. Registrar's department: _____</p>		<p>93. Registrar's division: _____</p>	
<p>94. Registrar's office: _____</p>		<p>95. Registrar's room: _____</p>		<p>96. Registrar's box: _____</p>	
<p>97. Registrar's phone: _____</p>		<p>98. Registrar's fax: _____</p>		<p>99. Registrar's email: _____</p>	
<p>100. Registrar's title: _____</p>		<p>101. Registrar's department: _____</p>		<p>102. Registrar's division: _____</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01232

1215

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDNA</b> First <b>ELIZABETH</b> Middle <b>RUSSELL</b> Last				4. DATE OF DEATH <b>January</b> Month <b>4</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 10, 1888</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>near Berryville, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Allen Russell</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Connie Russell</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO <b>Heart Failure</b> (c) <b>2 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-30-59</b> to <b>1-4-59</b> , that I last saw the deceased alive on <b>1-3-59</b> , 19 <b>59</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. W. Dutts</b>				ADDRESS (Street, city, town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>1/6/59</b>			
PHYSICIAN'S NAME (Type) <b>E. W. Dutts</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berryville, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Franklin Rogers</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

# CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY

Name of Deceased		Date of Death	
John Doe		January 1, 1955	
Age at Death		Sex	
45		Male	
Place of Birth		Cause of Death	
New York City		Heart Disease	
Occupation		Signature of Physician	
Teacher		John Doe, M.D.	
Signature of Registrar		Signature of Coroner	
John Doe		John Doe	
Date of Registration		Date of Burial	
January 1, 1955		January 1, 1955	
Place of Burial		Remarks	
Cemetery			

1219

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>9 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1215 Wabash Ave</b>				e. STREET ADDRESS <b>1215 Wabash Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ELMER</b> Last <b>SCHAEFFER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 24 1885</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman Brandt Cabinet Wks</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Path Valley Fulton Co</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jacob Schaeffer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Reeder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-2091</b>		17. INFORMANT <b>Mildred Vaughn 1215 Wabash Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Arterio-sclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12/10-1957</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchietasis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 10</b> , 19 <b>57</b> , to <b>Jan 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 17</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>1/19/59</b>			
PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md. Wash. DCo</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1220

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>50 Yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>				d. STREET ADDRESS <b>102 Broadway</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>102 Broadway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>AMELIA</b> Last <b>SCHINDEL</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>October 17 1871</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>		IF UNDER 24 HRS. Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John I. Harbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Martha Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hubert H. Schindel</b> Address <b>23 E. Irvin Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> <b>332x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> (c) <b>Severe Uncomplicated Arterio sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 weeks</b> <b>10 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 Dec</b> , 19 <b>58</b> , to <b>4 Jan</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4 Jan</b> , 19 <b>59</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F F Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Thomas</b>		DATE SIGNED <b>5 Jan 59</b>	
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>				<b>Hagerstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



22

1

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01235

1256

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Leitersburg</b>		c. LENGTH OF STAY IN 1b <b>20 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown #5</b>		d. STREET ADDRESS <b>Hagerstown #5</b>	
3. NAME OF DECEASED (Type or print) <b>William Neil Seilhamer</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1898</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landis Tool Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Near New Franklin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jefferson N. Seilhamer</b>		14. MOTHER'S MAIDEN NAME <b>Emma Kate Vandreau</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-03-3588</b>	
17. INFORMANT <b>Mrs. William N. Seilhamer, Hagerstown Md., #5</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic heart disease</b> ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 19 59</b> , to <b>Jan 11, 19 59</b> , that I last saw the deceased alive on <b>Jan 11, 19 59</b> , and that death occurred at <b>12:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph J. Miller</b>		DATE SIGNED <b>Waynesboro, Pa. 12 Jan 59</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH J. MILLER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter F. Groves, Waynesboro Pa.</b>		24a. REG'D BY REGISTRAR <b>Jan 14 59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Walter F. Groves</b>	

100-100000

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU ONE

CERTIFICATE OF DEATH

1900

RECEIVED  
JAN 11 1901  
BOSTON

DEATH NO. 100000

Name of deceased		Sex		Age		Date of death	
John Doe		Male		45		Jan 10 1901	
Place of birth		Usual residence		Cause of death		Manner of death	
New York		Boston		Heart disease		Natural	
Occupation		Signature of physician		Signature of registrar		Signature of informant	
Teacher		[Signature]		[Signature]		[Signature]	
Date of burial		Place of burial		Name of funeral home		Name of undertaker	
Jan 12 1901		Catholics		[Name]		[Name]	
Name of informant		Address of informant		Signature of informant		Signature of registrar	
[Name]		[Address]		[Signature]		[Signature]	
Date of registration		Place of registration		Name of registrar		Signature of registrar	
Jan 15 1901		Boston		[Name]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01236

1221

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>ELVIRA</b> Last <b>SHAFFER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6 1890</b>	
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Paper store</b>		11. BIRTHPLACE (State or foreign country) <b>Cearfoss Wash. Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>W. Martin sneckenberger</b>				14. MOTHER'S MAIDEN NAME <b>Mamie E. Hyde</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO. <b>218-30-9994</b>		17. INFORMANT <b>Edward F. Shafer Jr.</b> Address <b>355 So Potomac St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked congestive heart failure</b> DUE TO <b>Calcareous aortic stenosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>18 days -</b> (c) <b>18 years -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11/18, 1939</b> , to <b>1/29, 1959</b> , that I last saw the deceased alive on <b>1/29, 1959</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.				ADDRESS (Street, city or town, state) <b>154 West Washington St., 1:31:59</b>			
DATE SIGNED <b>1/29, 1959</b>							
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1921

STANDARD FORM NO. 100-10

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of undertaker		11. Signature of funeral home		12. Signature of cemetery	
13. Signature of health officer		14. Signature of coroner		15. Signature of justice of the peace		16. Signature of town clerk	
17. Signature of selectmen		18. Signature of school committee		19. Signature of board of health		20. Signature of board of selectmen	
21. Signature of board of health		22. Signature of board of selectmen		23. Signature of board of health		24. Signature of board of selectmen	
25. Signature of board of health		26. Signature of board of selectmen		27. Signature of board of health		28. Signature of board of selectmen	
29. Signature of board of health		30. Signature of board of selectmen		31. Signature of board of health		32. Signature of board of selectmen	
33. Signature of board of health		34. Signature of board of selectmen		35. Signature of board of health		36. Signature of board of selectmen	
37. Signature of board of health		38. Signature of board of selectmen		39. Signature of board of health		40. Signature of board of selectmen	
41. Signature of board of health		42. Signature of board of selectmen		43. Signature of board of health		44. Signature of board of selectmen	
45. Signature of board of health		46. Signature of board of selectmen		47. Signature of board of health		48. Signature of board of selectmen	
49. Signature of board of health		50. Signature of board of selectmen		51. Signature of board of health		52. Signature of board of selectmen	
53. Signature of board of health		54. Signature of board of selectmen		55. Signature of board of health		56. Signature of board of selectmen	
57. Signature of board of health		58. Signature of board of selectmen		59. Signature of board of health		60. Signature of board of selectmen	
61. Signature of board of health		62. Signature of board of selectmen		63. Signature of board of health		64. Signature of board of selectmen	
65. Signature of board of health		66. Signature of board of selectmen		67. Signature of board of health		68. Signature of board of selectmen	
69. Signature of board of health		70. Signature of board of selectmen		71. Signature of board of health		72. Signature of board of selectmen	
73. Signature of board of health		74. Signature of board of selectmen		75. Signature of board of health		76. Signature of board of selectmen	
77. Signature of board of health		78. Signature of board of selectmen		79. Signature of board of health		80. Signature of board of selectmen	
81. Signature of board of health		82. Signature of board of selectmen		83. Signature of board of health		84. Signature of board of selectmen	
85. Signature of board of health		86. Signature of board of selectmen		87. Signature of board of health		88. Signature of board of selectmen	
89. Signature of board of health		90. Signature of board of selectmen		91. Signature of board of health		92. Signature of board of selectmen	
93. Signature of board of health		94. Signature of board of selectmen		95. Signature of board of health		96. Signature of board of selectmen	
97. Signature of board of health		98. Signature of board of selectmen		99. Signature of board of health		100. Signature of board of selectmen	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01237

1222

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>18 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>324 WAKEFIELD ROAD</b>		e. STREET ADDRESS <b>324 WAKEFIELD ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN THOMAS SHANK</b>		4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 10, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GEN LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	9. AGE (In years last birthday) yrs. <b>85</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SHANK</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE MARTIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. RUTH MYERS GREENCASTLE, PENNA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic heart disease with failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the Prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 01, 1957</b> to <b>January 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>January 29, 1959</b> , and that death occurred at <b>4:00 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		<b>Clear Spring, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 2 '59</b>	
ADDRESS <b>CLEAR SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1223

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>664 Oak Ridge Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN</b> First <b>MARIE</b> Middle <b>SHANTZ</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 19, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Yeager</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Gates</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. George Shantz</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442 x</b> <b>Hypertensive Cardiovascular Renal disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept 9, 1941</b> , to <b>Jan 30, 1959</b> , that I last saw the deceased alive on <b>1-30-59</b> , 19 <b>59</b> , and that death occurred at <b>6:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert P. Conrad</b>		ADDRESS (Street, city or town, state) <b>1374 Washington</b>	
PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		DATE SIGNED <b>1-31-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/2/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Poyer</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1224

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD CALVIN SHUMAKER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fieman &amp; Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ribbon Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>162-12-0462</b>	
17. INFORMANT <b>Mrs. George Shumaker</b>		Address <b>Altoona, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute ventricular fibrillation</b> <b>420.1</b> DUE TO <b>arteriosclerotic myocardial, and coronary artery heart disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>heart disease</b> (a), stating the underlying cause lost. DUE TO <b>Pyelonephritis (chronic)</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/4/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carson Valley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Altoona, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Reuzer Funeral Home</b> <b>R. Franklin Reuzer</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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NOTES

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1225

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELVA</b> Middle <b>CATHERINE</b> Last <b>SINN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1882</b>
9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otho J. Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Emily C. Barger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Charles E. Sinn</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriolar nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 8, 1959</b> , to <b>January 19, 1959</b> , that I last saw the deceased alive on <b>January 18, 1959</b> , and that death occurred at <b>5:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg.</b> DATE SIGNED <b>1/20/59</b>			
ACTUAL SIGNATURE <i>W. D. Layman</i>		M.D. <b>100 Professional Arts Bldg.</b>	
PHYSICIAN'S NAME (Type) <b>William T. Layman</b>		<b>Hagerstown Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/22/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <i>R. Franklin Rouzer</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		White		Caucasian		35		April 15, 1902		New York City		April 15, 1902		New York City		Heart Disease		Natural		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Jane Smith		Female		White		Caucasian		28		March 10, 1903		New York City		March 10, 1903		New York City		Pneumonia		Natural		Jane Smith, M.D.		Jane Smith, M.D.		Jane Smith, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Robert Johnson		Male		White		Caucasian		42		January 5, 1901		New York City		January 5, 1901		New York City		Stroke		Natural		Robert Johnson, M.D.		Robert Johnson, M.D.		Robert Johnson, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Mary White		Female		White		Caucasian		30		February 1, 1902		New York City		February 1, 1902		New York City		Tuberculosis		Natural		Mary White, M.D.		Mary White, M.D.		Mary White, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
William Brown		Male		White		Caucasian		38		October 1, 1900		New York City		October 1, 1900		New York City		Heart Disease		Natural		William Brown, M.D.		William Brown, M.D.		William Brown, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Elizabeth Green		Female		White		Caucasian		25		November 15, 1903		New York City		November 15, 1903		New York City		Pneumonia		Natural		Elizabeth Green, M.D.		Elizabeth Green, M.D.		Elizabeth Green, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Thomas Black		Male		White		Caucasian		40		June 1, 1901		New York City		June 1, 1901		New York City		Stroke		Natural		Thomas Black, M.D.		Thomas Black, M.D.		Thomas Black, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Margaret Lee		Female		White		Caucasian		22		December 1, 1903		New York City		December 1, 1903		New York City		Tuberculosis		Natural		Margaret Lee, M.D.		Margaret Lee, M.D.		Margaret Lee, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Charles King		Male		White		Caucasian		33		March 1, 1902		New York City		March 1, 1902		New York City		Heart Disease		Natural		Charles King, M.D.		Charles King, M.D.		Charles King, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Anna Hall		Female		White		Caucasian		27		April 1, 1903		New York City		April 1, 1903		New York City		Pneumonia		Natural		Anna Hall, M.D.		Anna Hall, M.D.		Anna Hall, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Frank Miller		Male		White		Caucasian		36		May 1, 1901		New York City		May 1, 1901		New York City		Stroke		Natural		Frank Miller, M.D.		Frank Miller, M.D.		Frank Miller, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Grace Wilson		Female		White		Caucasian		24		June 1, 1903		New York City		June 1, 1903		New York City		Tuberculosis		Natural		Grace Wilson, M.D.		Grace Wilson, M.D.		Grace Wilson, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Henry Taylor		Male		White		Caucasian		39		July 1, 1900		New York City		July 1, 1900		New York City		Heart Disease		Natural		Henry Taylor, M.D.		Henry Taylor, M.D.		Henry Taylor, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Lillian Adams		Female		White		Caucasian		21		August 1, 1903		New York City		August 1, 1903		New York City		Pneumonia		Natural		Lillian Adams, M.D.		Lillian Adams, M.D.		Lillian Adams, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
George Baker		Male		White		Caucasian		41		September 1, 1901		New York City		September 1, 1901		New York City		Stroke		Natural		George Baker, M.D.		George Baker, M.D.		George Baker, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Helen Clark		Female		White		Caucasian		26		October 1, 1902		New York City		October 1, 1902		New York City		Tuberculosis		Natural		Helen Clark, M.D.		Helen Clark, M.D.		Helen Clark, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
James Evans		Male		White		Caucasian		37		November 1, 1900		New York City		November 1, 1900		New York City		Heart Disease		Natural		James Evans, M.D.		James Evans, M.D.		James Evans, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Katherine Foster		Female		White		Caucasian		23		December 1, 1903		New York City		December 1, 1903		New York City		Pneumonia		Natural		Katherine Foster, M.D.		Katherine Foster, M.D.		Katherine Foster, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Leo Green		Male		White		Caucasian		43		January 1, 1901		New York City		January 1, 1901		New York City		Stroke		Natural		Leo Green, M.D.		Leo Green, M.D.		Leo Green, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Mildred Hill		Female		White		Caucasian		20		February 1, 1904		New York City		February 1, 1904		New York City		Tuberculosis		Natural		Mildred Hill, M.D.		Mildred Hill, M.D.		Mildred Hill, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Nathan King		Male		White		Caucasian		44		March 1, 1900		New York City		March 1, 1900		New York City		Heart Disease		Natural		Nathan King, M.D.		Nathan King, M.D.		Nathan King, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Olivia Lee		Female		White		Caucasian		25		April 1, 1903		New York City		April 1, 1903		New York City		Pneumonia		Natural		Olivia Lee, M.D.		Olivia Lee, M.D.		Olivia Lee, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Philip Miller		Male		White		Caucasian		45		May 1, 1901		New York City		May 1, 1901		New York City		Stroke		Natural		Philip Miller, M.D.		Philip Miller, M.D.		Philip Miller, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Rebecca Wilson		Female		White		Caucasian		24		June 1, 1903		New York City		June 1, 1903		New York City		Tuberculosis		Natural		Rebecca Wilson, M.D.		Rebecca Wilson, M.D.		Rebecca Wilson, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Samuel Adams		Male		White		Caucasian		46		July 1, 1900		New York City		July 1, 1900		New York City		Heart Disease		Natural		Samuel Adams, M.D.		Samuel Adams, M.D.		Samuel Adams, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Tina Baker		Female		White		Caucasian		22		August 1, 1903		New York City		August 1, 1903		New York City		Pneumonia		Natural		Tina Baker, M.D.		Tina Baker, M.D.		Tina Baker, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Victor Clark		Male		White		Caucasian		47		September 1, 1901		New York City		September 1, 1901		New York City		Stroke		Natural		Victor Clark, M.D.		Victor Clark, M.D.		Victor Clark, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Wendy Evans		Female		White		Caucasian		21		October 1, 1903		New York City		October 1, 1903		New York City		Tuberculosis		Natural		Wendy Evans, M.D.		Wendy Evans, M.D.		Wendy Evans, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Xavier Foster		Male		White		Caucasian		48		November 1, 1900		New York City		November 1, 1900		New York City		Heart Disease		Natural		Xavier Foster, M.D.		Xavier Foster, M.D.		Xavier Foster, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Yvonne Green		Female		White		Caucasian		23		December 1, 1903		New York City		December 1, 1903		New York City		Pneumonia		Natural		Yvonne Green, M.D.		Yvonne Green, M.D.		Yvonne Green, M.D.	
Name of Deceased		Sex		Race		Color		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Zoe Hill		Female		White		Caucasian		24		January 1, 1904		New York City		January 1, 1904		New York City		Tuberculosis		Natural		Zoe Hill, M.D.		Zoe Hill, M.D.		Zoe Hill, M.D.	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WESTERN MARYLAND STATE HOSPITAL</b>				d. STREET ADDRESS <b>3635 CHESTNUT AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>JAMES</b> Last <b>SMALLWOOD</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 18, 1927</b>	9. AGE (In years last birthday) <b>31</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIRE WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TIRE</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Leonard Hessenauer (Same as Item # 2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONFLUENT LOBULAR PNEUMONIA</b> 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL CONGESTION &amp; EDEMA</b> DUE TO (c) <b>GLIOMA RIGHT FRONTAL LOBE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b>  <b>4 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 11</b> , 19 <b>58</b> , to <b>JAN. 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>JAN. 19</b> , 19 <b>59</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1500 PENNSYLVANIA AVE</b> DATE SIGNED <b>1/19/59</b>							
ACTUAL SIGNATURE <b>George Beran</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR. GEORGE BERCU</b> <b>HAGERSTOWN</b> <b>MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott &amp; Minnick</b> ADDRESS <b>San Nages Tron</b>				24a. REC'D BY REGISTRAR <b>JAN 21 59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01242

Reg. Dist. No.

1227

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HAROLD LEE SMITH</b>				4. DATE OF DEATH <b>JANUARY 25 19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/3/1958</b>	9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b>22</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>ERNEST M. SMITH</b>			14. MOTHER'S MAIDEN NAME <b>HILDA SUDER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. ERNEST M. SMITH</b>		<b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>491X</b> DUE TO <b>Bunchommonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>4 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>23 Jan 1959</b> , to <b>25 Jan 1959</b> , that I last saw the deceased alive on <b>24 Jan 1959</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 N. POTOMAC ST. HAGERSTOWN, MD.</b> DATE SIGNED <b>1/26/59</b>							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>J.D. WILSON</b>					
PHYSICIAN'S NAME (Type) <b>J.D. WILSON</b>		<b>HAGERSTOWN, MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horne</b> ADDRESS <b>Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>JAN 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Krasa</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1228

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>			d. STREET ADDRESS <u>430 Carlton Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Keefe</u> Middle <u>E</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>19 59</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General work</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Jacob Smith</u>		
14. MOTHER'S MAIDEN NAME <u>Nancy E. Misner</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW I</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Mrs. Ruth Feigley</u> Address <u>Hagerstown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd &amp; 3rd degree burns to head, face, torso,</u> <u>916.0</u> DUE TO <u>upper &amp; lower extremities</u> Conditions, if any, which gave rise to immediate cause (b) <u>Asphyxia due to smoke fumes</u> (a), stating the underlying cause lost. DUE TO <u>Smoke</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned while sleeping in bed and bed caught afire</u>			
20c. TIME OF INJURY Month, Day, Year <u>about 3:00 p.m. Jan. 8 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	
20f. (City or town) <u>Hagerstown</u>		(County) <u>Wash</u>		(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>1-9-59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>			ADDRESS <u>Hagerstown, Md.</u>		
24a. REC'D BY REGISTRAR <u>1 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraiss</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the Health, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW STATE  
DEATH NO.

DATE OF DEATH

TIME OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF SIGNATURE

PLACE OF SIGNATURE

1. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

2. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

3. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

4. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01244

1229

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN It <b>8 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>916 Marion St</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>916 Marion St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY JANE SNYDER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>October 31 1881</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wolfesville Fred Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Williams</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Oliver F. Smith</b>		Address <b>916 Marion St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a.) <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension Cardio Vascular System 3 yrs</b> DUE TO (c) <b>Cerebral Hemorrhage</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 mo</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-19-1958</b> to <b>1-24-1959</b> , that I last saw the deceased alive on <b>1-23-59</b> , 19____, and that death occurred at <b>9 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hagerstown Md 1/24/59</b>			
ACTUAL SIGNATURE <b>Dr. F. W. Little Jr</b>		M.D. <b>Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. F. W. Little Jr</b>		<b>Hagerstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 29 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

1924

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Usual Residence _____	
Cause of Death _____		Manner of Death _____	
Physician's Signature _____		Registrar's Signature _____	
Date of Certificate _____		Place of Death _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1230 CERTIFICATE OF DEATH

01245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Blair</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 12, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David F. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Adella Mills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>David F. Snyder</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> (c) <u>Cerebral Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-58</u> , 19 <u>58</u> , to <u>1-20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-10-59</u> , 19 <u>59</u> , and that death occurred at <u>4</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1-23-59</u>	
PHYSICIAN'S NAME (Type) <u>T. W. Kriss</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Rural Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tred W. Kriss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD  
1958  
CERTIFICATE OF DEATH

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Director, with

TO MR.  
VS A15  
15M 10.

1231

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>725 Orchard Road</b>		d. STREET ADDRESS <b>725 Orchard Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROGER</b> First <b>WILLIAM</b> Middle <b>SNYDER</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 26, 1915</b>
9. AGE (In years last birthday) <b>43 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco wholesaler Hagerstown, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul L. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Florence Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>220-10-3699</b>	
17. INFORMANT <b>Mrs. Anne Snyder</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. (b) <b>Carcinoma Epiglottis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephritis, Hypertension</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/26</b> , 19 <b>52</b> to <b>1/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1/10</b> , 19 <b>59</b> , and that death occurred at <b>9:10</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert Vh Campbell</b> M.D.		ADDRESS (Street, city or town, state) <b>145 W Washington St</b>	
DATE SIGNED <b>1/19/59</b>			
PHYSICIAN'S NAME (Type) <b>Robert Vh Campbell</b>		<b>Hagerstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>A. Franklin Suter</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Knecht</b>	

MEDICAL CERTIFICATION

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prior to burial, cremation, or removal, and in only event within 72 hours after death.

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Received 10 April 1997

100-9757-992-0000

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01248

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN lb <u>30 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. PAUL ST.</u>				d. STREET ADDRESS <u>ST. PAUL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTIN E. SUMMERS</u>				4. DATE OF DEATH Month <u>JANUARY</u> - Day <u>23</u> - Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16. 1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MOLESVILLE FRED. CO. MD. USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN SUMMERS</u>			
14. MOTHER'S MAIDEN NAME <u>MARY HOOVER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MRS. MARTHA SUMMERS BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Acute cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>J. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>J. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Jan. 23 - 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 25. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				ADDRESS <u>Boonsboro Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							



1232

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>16 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>2112 GAY ST.</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LULU</b> Middle <b>LEE</b> Last <b>STROUSE</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/1882</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM R. KIDNEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY M. SHRIVER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. CHARLES T. STROUSE</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>1 yr</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-14-59</b> , 19 <b>59</b> , to <b>1-14-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1-14-59</b> , 19 <b>59</b> , and that death occurred on <b>1-14-59</b> at <b>7:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.				DATE SIGNED <b>1-16-59</b>			
PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1233

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 month.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>DAVID</b> Last <b>SWANGER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Harrisburg, Penna.</b>
13. FATHER'S NAME <b>William Henry Swanger</b>		14. MOTHER'S MAIDEN NAME <b>Laura Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>195-07-8249</b>	
17. INFORMANT <b>M. Robt. Bailey</b>		Address <b>10 W. Baltimore St. Funkstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastasis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 14, 1958</b> to <b>Jan 11, 1959</b> , that I last saw the deceased alive on <b>Jan 11, 1959</b> , and that death occurred at <b>11:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Maryland</b> DATE SIGNED <b>1-12-59</b> ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D. PHYSICIAN'S NAME (Type) <b>E. W. Ditto III M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Orlino L. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COUNTY OF <u>ALLEGANY</u> CITY OF <u>UNION</u>		DECEASED <u>JOHN J. HARRIS</u>	
DATE OF DEATH <u>1914</u> PLACE OF DEATH <u>HOME</u>		SEX <u>MALE</u> AGE <u>65</u>	
OCCUPATION <u>LABORER</u> CAUSE OF DEATH <u>HEART DISEASE</u>		MEDICAL HISTORY <u>None</u>	
SIGNATURE OF DECEASED <u>None</u> SIGNATURE OF WITNESSES <u>None</u>		SIGNATURE OF PHYSICIAN <u>None</u>	
SIGNATURE OF CLERK <u>None</u> SIGNATURE OF REGISTRAR <u>None</u>		SIGNATURE OF JUDGE <u>None</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01250

Reg. Dist. No. 302

1234

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>10 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Martin Manor Nursing Home</b>				d. STREET ADDRESS <b>201 West Side Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANE ELIZABETH SWARTZ</b>			4. DATE OF DEATH Month Day Year <b>January 28 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1866</b>		9. AGE (In years last birthday) <b>92 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miliner</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Boonsboro, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>David Thum</b>			14. MOTHER'S MAIDEN NAME <b>Christianna Mc Crory</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Raymond B. Swartz Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Thrombosis</b> DUE TO <b>Artériosclerotic myocardial heart disease</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
				20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-29-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Berger</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Division

Division

Division

Division

201 West 1st Ave.

22 29

SWARTZ, J. J.

SWARTZ, J. J.

201 West 1st Ave.

201 West 1st Ave.

Boonville, Mo.

Boonville, Mo.

Christiansburg, Mo.

Christiansburg, Mo.

Boonville, Mo.

Boonville, Mo.

Boonville, Mo.

Boonville, Mo.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01251

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1235

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1 1/2 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>611 Sunset Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN WEBB TAYLOR</b>		4. DATE OF DEATH <b>January 8 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1, 1882</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR <b>4 Months 7 Days</b> IF UNDER 24 HRS. <b>4 Hours 7 Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Portsmouth, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew J. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Juliette Boyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Spanish-Amer.</b>		16. SOCIAL SECURITY NO. <b>705-10-5217</b>	
17. INFORMANT <b>Mrs. Ada Taylor</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fracture of skull</b> DUE TO <b>Laceration of brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple fracture of ribs</b> DUE TO <b>Shock</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Glaucoma</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down the basement stairs</b>	
20c. TIME OF INJURY <b>12:30 a.m. Jan. 8 1959</b>	20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Hagerstown</b> (County) <b>Wash</b> (State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rouzer</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Examination

Examination of the body of

Washington County Hospital

John

White

October 1, 1962

Residence

Hallam

Orangetown, Ohio

Dr. J. Taylor

Intense

Yes

Gravely - yes, 10-1-62

Dr. J. Taylor - Orangetown, Ohio



1236

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>81 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>				1 d. STREET ADDRESS <u>224 W. Franklin Street</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>M</u> Last <u>Titlow</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1877</u>	
				9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Titlow</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, rt. lower lobe</u> 602x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perinephritic abscess, rt. kidney</u> DUE TO <u>Pyelonephroses</u> (c) <u>Hydronephroses &amp; Nephrolithiasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>1. Thrombosis, middle cerebral artery; 2. adenocarcinoma of Fundus of uterus</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7</u> , 19 <u>57</u> , to <u>January 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 4</u> , 19 <u>59</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Western Md. State Hosp.</u> DATE SIGNED <u>Jan. 4, 1959</u>							
ACTUAL SIGNATURE <u>Victor L. Ramos</u>				M.D. <u>Western Md. State Hosp.</u>			
PHYSICIAN'S NAME (Type) <u>VICTOR L. Ramos</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith - Rouse, Funeral Home</u> <u>R. Franklin Rouse</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED'S NAME LAST, FIRST, MIDDLE SUFFIX		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
DATE OF BIRTH MONTH DAY YEAR		PLACE OF BIRTH CITY, STATE, COUNTRY	
DATE OF DEATH MONTH DAY YEAR		PLACE OF DEATH CITY, STATE, COUNTRY	
TIME OF DEATH HOUR MINUTE		CAUSE OF DEATH (List all causes, beginning with immediate cause, and giving the underlying cause)	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)		MEDICAL HISTORY (List all diseases, injuries, operations, etc., which may have contributed to the death)	
OCCASION OF DEATH (List all events which may have contributed to the death)		SIGNATURE OF PHYSICIAN (Print name and title)	
SIGNATURE OF REGISTRAR (Print name and title)		SIGNATURE OF WITNESS (Print name and title)	
SIGNATURE OF DECEASED'S NEXT OF KIN (Print name and title)		SIGNATURE OF DECEASED'S ATTORNEY (Print name and title)	
SIGNATURE OF DECEASED'S MINISTER OF RELIGION (Print name and title)		SIGNATURE OF DECEASED'S CHURCH (Print name and title)	
SIGNATURE OF DECEASED'S FUNERAL HOME (Print name and title)		SIGNATURE OF DECEASED'S BURIAL PLACE (Print name and title)	
SIGNATURE OF DECEASED'S CEMETERY (Print name and title)		SIGNATURE OF DECEASED'S INTERMENT (Print name and title)	
SIGNATURE OF DECEASED'S CREMATION (Print name and title)		SIGNATURE OF DECEASED'S OTHER (Print name and title)	

REGISTERED



1237

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>7 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Peter</b> Last <b>Vantz</b>		4. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7. 1974</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles J Vantz</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Shives</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-38-1657</b>	
17. INFORMANT <b>Thomas Vantz Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion with myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 13, 19 59</b> , to <b>January 13, 19 59</b> , that I last saw the deceased alive on <b>January 13, 19 59</b> and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.		PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Maryland</b> <b>January 14, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.16.59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peters Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INMURDERED

1920

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1258

## CERTIFICATE OF DEATH

01254

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>				c. LENGTH OF STAY IN 1b <u>38 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harman</u> Middle <u>Luther</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1900</u>	9. AGE (In years lost birthday) yrs. <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Boonsboro, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Emory W. Wade</u>				14. MOTHER'S MAIDEN NAME <u>Ida Haller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Achsah Wade, Smithsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Carcinoma with Metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>9-27</u> , 19 <u>58</u> , to <u>1/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 2</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>		<u>Smithsburg, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 5 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Kiser</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1259 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TREGO</b>			c. LENGTH OF STAY IN 1b <b>53 YEARS</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>TREGO</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TREGO</b>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>WADE</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 9 1879</b>		9. AGE (In years lost birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R. CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BAKERSVILLE WASH. CO. MD. U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM WADE</b>			14. MOTHER'S MAIDEN NAME <b>RUANN HINES</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>AMOS W. WADE TREGO WASH. CO. MD.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Generalized arteriosclerosis -</b> DUE TO <b>Cerebral Hemorrhage -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage -</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b> <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>Jan</b>	Day <b>9</b>	Year <b>1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 10, 1956</b> , to <b>January 9, 1959</b> , that I last saw the deceased alive on <b>Jan. 9, 1959</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>J. W. Lellan</b>			ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b>		DATE SIGNED <b>1/10/59</b>	
PHYSICIAN'S NAME (Type) <b>G. W. He Van</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>		<b>JANUARY 12 1959</b>		<b>LOCUST GROVE CEMETERY</b>		<b>LOCUST GROVE WASH. CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>			ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>Jan 14 '59</b>	
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES H. HARRIS		M		45		W		1910		BALTIMORE, MD.		1955		BALTIMORE, MD.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
None		Heart Disease		Natural		None		None		None		None		None	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF DEPUTY CLERK	
None		None		None		None		None		None		None		None	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. RACE  
5. DATE OF BIRTH  
6. PLACE OF BIRTH  
7. DATE OF DEATH  
8. PLACE OF DEATH  
9. OCCUPATION  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. MEDICAL HISTORY  
13. PRESENT ILLNESS  
14. TREATMENT  
15. POST-MORTEM  
16. SIGNATURE OF PHYSICIAN  
17. SIGNATURE OF REGISTRAR  
18. SIGNATURE OF WITNESS  
19. SIGNATURE OF PHYSICIAN  
20. SIGNATURE OF CORONER  
21. SIGNATURE OF JURY  
22. SIGNATURE OF JUDGE  
23. SIGNATURE OF CLERK  
24. SIGNATURE OF DEPUTY CLERK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1238

## CERTIFICATE OF DEATH

01256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>75 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1021 CORBETT ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>JEFFERSON</b> Middle <b>WHITE</b> Last		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/1859</b>
9. AGE (In years last birthday) <b>99</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTAR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENL. HOUSE CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. CAPTOLIA BURGER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>1-2 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-12-59</b> , 19____, to <b>1-29-59</b> , 19____, that I last saw the deceased alive on <b>1-29-59</b> , 19____, and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>1-30-59</b>			
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hermant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	



1239

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>EARL</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1895</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Dgys <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Assembly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Foundry</b>	11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Homer C. Williams</b>	
14. MOTHER'S MAIDEN NAME <b>Martha ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>214-C9-3428</b>		17. INFORMANT <b>Mrs. Ruth Williams</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic heart disease</b> DUE TO (b) <b>10 yrs.</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis &amp; partial hemiplegia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> to <b>1959</b> , that I last saw the deceased alive on <b>9 Jan</b> , 1959, and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 W. Welch</b> DATE SIGNED <b>1/12/59</b> ACTUAL SIGNATURE <b>E. Eden G. Hoachlun</b> M.D. PHYSICIAN'S NAME (Type) <b>E. Eden G. Hoachlun Hagerstown</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/13/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Franklin Poyser</b>		24a. REC'D BY REGISTRAR DATE <b>1/13/59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kane</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 302

Name of Deceased		John A. Williams	
Age		45	
Sex		Male	
Race		White	
Date of Death		March 2, 1952	
Place of Death		Washington County Hospital	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		March 5, 1952	
Place of Registration		Washington County, Md.	
Signature of Registrar		[Signature]	

RECEIVED  
MARCH 10 1952  
BALTIMORE, MD  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1240

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LYN</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 19, 1959</b>
9. AGE (In years last birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Donald F. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Vussell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Donald F. Williams</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Atelectosis</b> DUE TO <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immaturity</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 19, 1959</b> , to <b>Jan. 19, 1959</b> , that I last saw the deceased alive on <b>Jan. 19, 1959</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. W. Done Jr.</b>		DATE SIGNED <b>Jan 20, 1959</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/20/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Bouzer Funeral Home</b> <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081273 XVO

# CERTIFICATE OF DEATH

Washington

Leah Land

Washington

Washington

Leah Land

Leah Land

Leah Land

Leah Land

Leah Land

January 19, 1939

January 19, 1939

January 19, 1939

January 19, 1939

January 19, 1939

January 19, 1939

January 19, 1939

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01259

Reg. Dist. No. 302

1241

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1845 Fountainhead Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CARL HILTON WITTMER</b>		4. DATE OF DEATH <b>January 26 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1946</b>
9. AGE (In years last birthday) <b>12 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl S. Wittmer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Carl S. Wittmer</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound (22 calibre) into abdomen</b> <b>919.0</b> DUE TO <b>Hemorrhage and shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>45 min</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>region</b> <b>Shot self in epigastrium while showing gun to aunt</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:45 p.m. Jan. 26 1959</b>	20d. INJURY OCCURRED <b>at home</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>1-27-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/29/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Ronger</b>		24a. REC'D BY REGISTRAR <b>JAN 29 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krouse</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH RECORD 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

124

County of Washington  
City of Washington  
District of Columbia

Residence of Deceased  
Washington, D.C.

Washington County Hospital

Age of Deceased  
35 years

Sex of Deceased  
Male

Occupation of Deceased  
Student

Name of Deceased  
Carl S. Wilson

Signature of Medical Examiner  
Carl S. Wilson, M.D.

Done

At

Witnessed by  
J. Edgar Hoover, Director, Federal Bureau of Investigation

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

Signature of Medical Examiner  
J. Edgar Hoover

1260

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ZITTLESTOWN-RURAL</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. 12.2</u>				d. STREET ADDRESS <u>BOONSBORO MD. 12.2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVEY - CONROY - ZITTLE</u>				4. DATE OF DEATH Month Day Year <u>JANUARY - 15 - 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 20 - 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL BUILDING</u>			
13. FATHER'S NAME <u>NO RECORD</u>				14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-3507</u>			
17. INFORMANT <u>MRS. IONA O. POFFENBERGER</u>				Address <u>BOONSBORO MD. 12.2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer?</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Smooth</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>58</u> , to <u>Jan 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>59</u> , and that death occurred at <u>7:01</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro Md</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>1-17-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 18 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 20 59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01201

MARYLAND STATE DEPARTMENT OF HEALTH - EASTERN DISTRICT

CERTIFICATE OF DEATH

389

DATE OF DEATH

DECEASED

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

MARITAL STATUS

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

JOHN D.

